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HIGH PRICES, LOW TRANSPARENCY: THE BITTER PILL OF HEALTH CARE COSTS

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BEFORE THE

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HIGH PRICES, LOW TRANSPARENCY: THE BITTER PILL OF HEALTH CARE COSTS

TUESDAY, JUNE 18, 2013

U.S. SENATE,
COMMITTEE ON FINANCE,
Washington, DC.

The hearing was convened, pursuant to notice, at 10:03 a.m., in room SD–215, Dirksen Senate Office Building, Hon. Max Baucus (chairman of the committee) presiding.

Present: Senators Rockefeller, Wyden, Schumer, Nelson, Menendez, Brown, Bennet, Casey, Hatch, Crapo, Thune, Burr, and Toomey.

Also present: Democratic Staff: Mac Campbell, General Counsel; David Schwartz, Chief Health Counsel; Tony Clapsis, Professional Staff Member; and Karen Fisher, Professional Staff Member. Republican Staff: Kristin Welsh, Health Policy Advisor.

OPENING STATEMENT OF HON. MAX BAUCUS, A U.S. SENATOR FROM MONTANA, CHAIRMAN, COMMITTEE ON FINANCE

The CHAIRMAN. The committee will come to order.

President Franklin Roosevelt once said that the best way to address a problem is, "In the cold light of day, to analyze it, to ask questions, to call for answers, to use every knowledge, every science we possess, to apply common sense."

Journalist Steven Brill's March 4th *Time* magazine article, "The Bitter Pill: Why Medical Bills Are Killing Us," detailed the problem of skyrocketing health care bills in the cold light of day. We are fortunate to have Mr. Brill with us today to analyze the problem, to use knowledge, and to apply common sense.

Mr. Brill shares the stories of uninsured and under-insured Americans who survived life-threatening diseases, but their lives were nearly ruined by medical bills they could not afford. We learned about Sean Recchi from Ohio. Sean was diagnosed with non-Hodgkins lymphoma last year at the age of 42.

Sean and his wife had just started their own business and were only able to afford a limited health insurance plan, but the hospital did not accept his discount insurance. So the hospital made Sean pay nearly $84,000 in advance for a treatment plan and an initial dose of chemotherapy.

Sean was billed off the hospital's internal list price, known as the "chargemaster." The chargemaster is like the sticker price of a new car: it is inflated. Few would ever pay it. In the case of hospitals, the list price is not just a 5-, 10-, or 15-percent mark-up; it could be 100 times higher.

But, unlike new cars, some people have no choice but to pay the chargemaster price. Who are these people? The uninsured and the under-insured, people like Sean Recchi. To start receiving life-saving care, Sean needed to pay 170 percent of the average American's salary to a hospital, a nonprofit hospital, and that was just for his first treatment. Mr. Brill's article shines a light on the little-known chargemaster system used by America's hospitals.

Mr. Brill also tells the story of Rebecca and Scott S., a couple in their 50s living near Dallas. One day last year Scott was having trouble breathing. Rebecca raced him to the hospital. She thought he was about to die. Scott stayed in the hospital for about 32 days until his pneumonia was brought under control. Rebecca and Scott never imagined that this near-death experience would wipe out their life's savings. They exceeded their insurance annual limit and were left with a $313,000 bill.

Thanks to health reform, these stories will soon be a thing of the past. The Affordable Care Act will ensure heartbreaking stories like Scott's and Sean's are no longer the norm. The law got rid of lifetime limits, and by next year the law will eliminate annual limits as well. Families like Rebecca and Scott's will no longer face crippling debt as a result of illness. Insurance companies will be required to cover the medical services they need.

By 2016, the law will also provide coverage to 26 million Americans who were previously uninsured. The health reform law also prevents hospitals from over-billing uninsured patients using inflated chargemaster prices. The administration needs to act quickly to finalize the regulations related to this provision.

The Affordable Care Act also helped increase transparency of what hospitals charge Medicare. I applaud Medicare for releasing chargemaster data on inpatient and outpatient hospital stays over the last 2 months. We need to build on this and take a comprehensive look at transparency from the perspective of the consumer.

Some innovative firms like Castlight Health and Change Healthcare are doing just this: they are pioneering analytical tools that can zero in on meaningful pricing information. These tools can help Americans be smarter consumers. They can help employers and plans form better partnerships with providers. They can help keep costs down. Unfortunately, these tools are not widely available, however—not yet. I hope they will be soon—to the average consumer.

While increased transparency has the potential to change behavior, we will also expose the real thrust of Mr. Brill's article: health care prices are too high in the United States. Today's hearing will explore the causes of these high prices.

Specifically, I hope we can examine the consolidation of hospitals and physicians. The practice can often help produce more integrated care, but consolidation can also lead to higher prices for patients.

I also hope to look at the medical device sector that often reaps record-high profits, including gross profit margins approaching 75 percent. We need to see if barriers exist that prevent hospitals from more aggressively bargaining for lower prices. If they do, we need to tear them down.

This hearing is an opportunity to start working through these issues. We know there is a problem. It has been portrayed in the cold light of day by Mr. Brill. We are here, as President Roosevelt urged, to ask the questions, to analyze the problem. So let us apply a little common sense. Let us continue to make health care more transparent and affordable. And let us not stop working until we finish the job we started with health reform.

I look forward to our witnesses. They have spent a lot of time thinking about this, and I know they will have a lot to say.

[The prepared statement of Chairman Baucus appears in the appendix.]

The CHAIRMAN. Senator Hatch?

OPENING STATEMENT OF HON. ORRIN G. HATCH, A U.S. SENATOR FROM UTAH

Senator HATCH. Thank you, Mr. Chairman, for convening this hearing this morning. To be honest, I am not sure where to begin. As we all know, the original impetus for this hearing was the recent article in *Time* magazine about the costs associated with health care, Mr. Brill's article.

While that article did not present much in the way of new information, he reminded all of us how complicated our health care system is and how our system of fee-for-service reimbursement has resulted in tremendous cost growth over the last 2 decades.

Congress has had discussions about the cost of health care for years. Unfortunately, I think the President's health care law missed a real opportunity to address these issues. We know that there are many factors that drive up the cost of care, some appropriate and some not.

Those of us who got through the more than 35 pages of the *Time* article know that each sector of the health care industry must play a part if we are going to be successful in creating a more rational and affordable system.

Some have suggested comparing purchasing decisions in our health care system to those of other industries, such as airlines, cars, or hotels. With those types of purchases, websites and other avenues exist that allow consumers to readily find price information and customer reviews.

While I agree this is a very rational way to shop, we have to acknowledge that health care is very different. Many factors go into pricing health care, factors such as specialty of the provider, severity of the patient condition, level of resource use, et cetera. Different payers reimburse at different levels.

As many have noted, we have one of the best health care systems in the world, but there is a significant debate as to whether our outcomes are good enough to justify all the costs.

This year, Americans will spend $2.8 trillion on health care, and, of that, Medicare will spend $800 billion. In Congress, we tend to focus mostly on spending in Medicare and other Federal programs, but the enormous amount spent in the overall health care system needs to be examined.

For employers who provide coverage to their employees, the rising cost of goods and services that make up our health care system are very real. Increased costs mean less money that can be spent

on wages or other benefits and, perhaps more importantly, less money to spend on hiring additional employees. For individuals, as the costs continue to increase and employers have to scale back, their out-of-pocket health care costs will only go up.

The issue that most directly affects people, whether they have health insurance or not, is their out-of-pocket costs. Most people are not interested in irrelevant hospital chargemasters or the details of health plan negotiations; they simply want to know what they will be paying themselves at the end of the day.

For savvy consumers who will spend time up front researching costs and quality data, they want easy-to-understand information to help them make decisions. For others, it is as simple as receiving a bill that is, as they say, patient-friendly.

As I stated, this is a very complicated issue, and many factors need to be considered. Most of us would agree that competition in health care is generally a good thing. Hospitals, physicians, suppliers, and payers should all compete on quality and price, and consumers should benefit from this. However, in many parts of the country, consolidation, whether it is provider or payer consolidation, has often led to higher prices without better quality outcomes.

Mr. Chairman, I think this is an area that is worth further exploration in the future. Many of the policies that Congress has enacted, like for example Accountable Care Organizations, bundled payments, or health information technology requirements, lead to greater consolidation.

It is important that we know the consequences of some of these policies. I also believe, as a former medical liability defense lawyer, that medical liability costs are driving an awful lot of the costs that are eating us alive in our society today and that most of the cases that are brought are basically frivolous, to get the defense costs, which are enormous.

Lastly, let me echo the point made in Mr. Brill's article about the cost of defensive medicine. As the article stated, much of the high cost of health care is due to over-utilization of services as a means of protecting the physician against future litigation. That is what we advised when we saw this influx of medical liability cases when they changed the basic laws to make every case a case that goes to the jury.

Physicians have been very, very concerned about future litigation. In light of this fact, I hope the Congress will work to pass legislation to address medical liability reform. This was another missed opportunity in Obamacare, but it is not too late to fix that.

Chairman Baucus, thank you once again for convening this hearing today. I look forward to hearing from our witnesses and learning about how we can harness the wealth of information available to citizens to help them to make good decisions. These consumers need that so they can make good decisions about their health care.

Thank you, Mr. Chairman.

The CHAIRMAN. Thank you, Senator, very much.

[The prepared statement of Senator Hatch appears in the appendix.]

The CHAIRMAN. Today our four witnesses are as follows. Mr. Steven Brill is the author of the *Time* magazine article, "Bitter Pill: Why Medical Bills Are Killing Us." Next is Dr. Suzanne Delbanco,

executive director of Catalyst for Payment Reform. Welcome. Dr. Paul Ginsburg—welcome back, Dr. Ginsburg—is president of the Center for Studying Health System Change. And Dr. Giovanni Colella is CEO and Co-Founder of Castlight Health.

We will begin with you, Mr. Brill. You are the star witness here. Our usual practice is for statements to be automatically included in the record and then for you to summarize your statements cogently. Do not pull any punches. Tell us what you think.

Mr. Brill, go ahead.

STATEMENT OF STEVEN BRILL, J.D., CONTRIBUTING EDITOR, *TIME* MAGAZINE, NEW YORK, NY

Mr. BRILL. Thank you for inviting me, Mr. Chairman and Mr. Ranking Member, to discuss what I found when I dissected seven medical bills, as you know, line by line to see why health care costs so much in the United States.

I found that, by any definition, this is no one's idea of a functioning marketplace. In a functioning marketplace, prices are based on something that is explainable, whether it is the cost of producing the product, or the laws of supply and demand, or the quality of the product.

In this marketplace, no one can explain a hospital's charge of $77 for a box of gauze pads. No one can explain an $87,000 bill for a few hours of outpatient care. That bill included $3 for the magic marker that marked the spot where a neurostimulator would be inserted into the patient's back. He was then charged $49,000 for the neurostimulator, which cost the hospital about $19,000, and it was paid to a manufacturer whose gross profit margin is nearly double Apple's.

No one can explain why a school bus driver was charged, and sued into paying, $9,400 after she fell and spent 2 hours in the Bridgeport Hospital E.R., where among the charges was $239 for a blood test that Medicare, which pays hospitals based on their actual costs, would pay $13.94 for.

No one can explain anything about what I discovered was a massive, out-of-control internal price list called the chargemaster. All hospitals and labs have one, but they vary wildly and have nothing to do with quality.

The reason no one can explain any of this is simple: nobody has to, because this is not a functioning marketplace. It is a casino where the house holds all the cards. That school bus driver did not wake up one morning and say to herself, oh, I wonder what they have on sale over at the emergency room today; maybe I will go have a look. When she became that hospital's customer, she not only had no price information, she also had no choice.

The result is an economy a world apart from the economy that the rest of us live in. While things have been tough for most Americans in the last half decade, those who run hospitals or sell CT scans or drugs or medical devices have thrived, as if living in an alternate universe.

In hundreds of cities and towns, tax-exempt, ostensibly nonprofit hospitals have become the community's most profitable businesses, often presided over by the region's most richly compensated executives. So that is what I saw when I followed the money.

What can we do about it? Well, the first step, obviously, must be transparency. None of this will change until we can see it all, so that those involved can be asked to answer for those salaries, those out-sized profit margins on drugs and medical devices, and, above all, the bizarre differences in prices everywhere you look.

But transparency can only go so far. Let us consider the man who was asked to pay $13,702 for his first transfusion of the cancer drug that he desperately needed. Now, suppose he knew that the drug only cost the ostensibly nonprofit hospital maybe $3,500 and that it cost the drug company a few hundred dollars.

Suppose he even knew that among the $71,000 in other charges, he was getting soaked for $77 for a box of gauze pads or $15,000 for lab tests for which Medicare would pay just a few hundred dollars. What if knew all that? So what? What could he do? He could feel the tumor growing in his chest, his wife told me, and he was desperate for his check to clear.

In fact, they kept him waiting downstairs for his transfusion until it did clear. So we need more than transparency. My written testimony, as well as the *Time* article, make a lot of suggestions in that regard, but I will close by emphasizing again that, while transparency starts the conversation about prices that we did not have in the debate over Obamacare, it is only a start.

I might add that Obamacare itself does nothing about these prices, nothing to solve this problem—zero. Once we follow the money in this lopsided sellers' marketplace, we have to act to stem the flow by doing something about these prices.

Thank you.

The CHAIRMAN. Thank you very much, Mr. Brill.

[The prepared statement of Mr. Brill appears in the appendix.]

The CHAIRMAN. Dr. Delbanco?

STATEMENT OF SUZANNE DELBANCO, Ph.D., EXECUTIVE DIRECTOR, CATALYST FOR PAYMENT REFORM, SAN FRANCISCO, CA

Dr. DELBANCO. Thank you. Chairman Baucus, Ranking Member Hatch, and distinguished committee members, I am here to tell you that employers and consumers need price transparency. While I am currently executive director of Catalyst for Payment Reform, I was the founding CEO of another nonprofit, the Leapfrog Group, which pioneered the public reporting of hospital quality and safety information, so transparency in health care is an issue I have been working on for 13 years.

Catalyst for Payment Reform is an independent nonprofit organization working on behalf of large employers and other health care purchasers to promote a higher-value health care system in the United States. Currently, CPR has 30 members, including Boeing, Dow Chemical Company, Safeway, as well as eight State agencies, including 4 Medicaid agencies.

CPR designated price transparency as a top priority because we cannot imagine a high-value health care system without it. As you know, employers and other health care purchasers, as well as consumers, are facing rising health care costs.

In response, employers are asking their beneficiaries to take on a greater share of those costs, as well as designing benefit plans

that push users toward more efficient, higher-quality choices. Purchasers believe that pressure from consumers is an under-utilized lever, but consumers need information to make good decisions. Consumers do not expect prices for the same service to vary so much. One example was found that the price for colonoscopy varied 10-fold within one market.

Furthermore, employers in health plans cannot implement some of those promising strategies to stem costs without price transparency. Something called reference pricing is an example of such an approach. Reference pricing sets a standard price for a drug, procedure, or service, and requires health plan members to pay any amount above it.

For example, CALPERS, California's Public Employee Retirement System, set a reference price of $30,000 for hip and knee replacements. If a patient chooses to seek a hip or knee replacement from a more expensive facility, they do have to pay the difference. CALPERS has said that this program has reduced its costs in this area by 30 percent.

This approach enables purchasers to let providers know that their unwarranted price variation is no longer going to be tolerated and also gives them a chance to engage consumers in making higher-value choices.

There are many efforts to promote price transparency today. As you know, CMS provides an online tool that provides beneficiaries with estimated out-of-pocket drug costs, and of course CMS just released some hospital charge information. Thirty-four States also require reporting of hospital charges or reimbursement rates.

But, in a report card on State price transparency laws that we co-authored, we found that most State laws fall far short of making sure that consumers get the information they need. Many challenges remain.

Some health care providers prohibit health plans from sharing any information about what they get paid. While health plans are working to phase out these agreements—and they are relatively rare—in the markets that they affect, they can leave gaping holes in the information that consumers need.

Another barrier is that some health plans feel the information about what they pay providers is proprietary, making employers have to rely on the health plan to inform consumers even if they feel another vendor is better suited to do it.

CPR has been supporting its members to become a critical mass, pushing for health plans and providers to remove these barriers. We supply members with questions to ask prospective health plan partners and model terms for their contracts for the plans. We facilitate meetings for them to discuss price transparency on a quarterly basis with some of the Nation's largest plans.

We have also outlined specifications for how we think price information can best be conveyed to consumers. One of today's biggest shortcomings is the separation of price and quality information, making it hard for consumers to choose the best overall choice.

The Federal Government could facilitate transparency in a variety of ways. First, it could share more charge, payment, and quality information on a broader range of services and providers.

Second, it could make sure that its own consumer transparency tools, like *hospitalcompare.gov*, incorporate the features that CPR highlights in its specifications as being important.

Third, the Federal Government could, through the federally facilitated exchanges, insist on price transparency from the qualified health plans. CPR's model contract language could help here.

Lastly, to help employers meet their fiduciary obligations, the Federal Government could ensure that employers have access to their own claims data for use in consumer transparency tools.

Again, I am here to tell you that employers and consumers need price transparency in health care. Catalyst for Payment Reform commends the Senate Finance Committee for delving into this issue. Thank you.

The CHAIRMAN. Thank you, Dr. Delbanco.

[The prepared statement of Dr. Delbanco appears in the appendix.]

The CHAIRMAN. Dr. Ginsburg, you are next.

STATEMENT OF PAUL GINSBURG, Ph.D., PRESIDENT, CENTER FOR STUDYING HEALTH SYSTEM CHANGE, WASHINGTON, DC

Dr. GINSBURG. Yes. Mr. Chairman, Senator Hatch, members of the committee, I appreciate the opportunity to talk about price transparency. I particularly will focus on policy initiatives.

Many policy activities related to health price transparency have missed the mark. They are focused on transparency for transparency's sake rather than on getting lower prices for consumers, which is what I believe the principal goal should be.

The best that could be said is that releases of price data have increased awareness of policymakers, employers, and the public concerning how widely prices vary from one area to another and across providers in a single market.

But this accomplishment is limited when releases focus on billed charges which have little relationship to the prices that are actually paid on behalf of virtually all patients. The recent CMS release of hospital charge data suffers from this problem.

A notable exception are the various reports from the Massachusetts Attorney General that released data on what private insurers pay each hospital. These releases have in fact led to State policies that have facilitated insurance designs that reward consumers that use lower-priced hospitals.

But the data releases alone will not reduce price variation. Policymakers must either take steps to make health care markets more competitive or regulate prices, and large employers need to change the design of their benefits.

I also worry about transparency proposals that advocate publication of the specifics of contracts between insurers and providers. Antitrust policies throughout the world seek to prohibit the publication of contract prices in markets that are concentrated, because of the risks that sunshine will lead to higher prices. These risks can be reduced substantially if discretion is used to shield the details.

The key to price transparency leading to lower prices for consumers is benefit designs that offer rewards to them. Not only will such approaches yield savings to those who choose lower-priced

providers, but, if enough are involved, incentives for providers to improve their value will be created.

High-deductible plans provide such incentives for outpatient care, telling patients the prices that they will pay under their plan when using different providers—of course, others on the panel are discussing this—but they have little impact on choosing hospitals for inpatient care, because most enrollees exceed their high deductibles when they go into the hospital.

I believe the greatest potential for obtaining lower prices comes from approaches where purchasers and health plans, rather than report prices to enrollees, analyze the complex data on costs and quality and provide simple incentives for enrollees to choose higher-value providers.

We see this approach in tiered network designs that major insurers are pursuing in Massachusetts and some other places. In fact, in Massachusetts, enrollees tend to pay three different deductible amounts for hospital care according to the tier of the hospital they choose.

We see this approach in reference pricing, such as the initiative of CALPERS that Dr. Delbanco mentioned for hip and knee replacements. These approaches are less transparent than publishing prices for services, but they are likely a lot more effective.

So what should policymakers do to get lower prices for health care? Well, two steps were already taken that will contribute a lot, and I am referring to the Cadillac tax and the structure of the premium tax credits in the Affordable Care Act, because these provisions will put a lot of pressure on premiums, and the result will be benefit designs that encourage enrollees to choose providers on the basis of value.

Providing employers, insurers, and consumer organizations with better data on provider practice patterns, such as the legislation introduced today by Senators Grassley and Wyden to make Medicare data more accessible, would accomplish this.

Also, there is opportunity to prohibit some anti-competitive contracting practices that block approaches, such as tiered networks and reference prices. Thank you very much.

The CHAIRMAN. Thanks, Dr. Ginsburg, very much.

[The prepared statement of Dr. Ginsburg appears in the appendix.]

The CHAIRMAN. Dr. Colella?

STATEMENT OF GIOVANNI COLELLA, M.D., CEO AND CO-FOUNDER, CASTLIGHT HEALTH, SAN FRANCISCO, CA

Dr. COLELLA. Thank you very much. Chairman Baucus, Ranking Member Hatch, distinguished members of the committee, thank you very much for inviting me today. It is an honor and a pleasure for me to be here.

Almost 29 years ago to the day, I came to this country to complete my medical training. While I have since then become an interpreter, my goal and my dream has remained the same: I want to improve the health and the well-being of my fellow Americans.

I first became aware of price transparency, and admittedly a little bit obsessed with it, a few years ago when my mother, who was very sick and ill, needed medical care. As hard as I tried, looking

everywhere, me, a trained physician, could not get the basic facts about the quality and the cost for her care.

I could not determine if a name-brand hospital, a famous medical center, was indeed the best place for my mother to receive care. On top of this, I was unable to determine how much that care might cost. All this surprised me.

Now, if I go shopping for a car, I know the price; it is right there. It is on the window. I see it right away, and there is plenty of information on the quality of this. Yet, when it comes to our health care system, it is virtually impossible to find out cost and quality of what I am buying.

Now, this makes absolutely no sense. Consumers ultimately end up paying more and getting worse care, and we as a country end up spending more on health care than we need to. Years of study and real-life experience demonstrate a huge variation in price and quality across our country, across individual States, across individual cities, and, even more, across individual doctors practicing in the same hospital.

Now, let me be clear. We can spend much less as a Nation than we currently do on health care and still receive much higher quality care. This is because, when it comes to health care, there is absolutely no correlation between price and quality. Let me be more specific: almost no correlation between price and quality.

Now, let me use an example for this. The price of care for a typical pregnancy for a commercially insured woman in the city of Chicago—the most expensive hospital in Chicago actually has the poorest quality rating, while the least expensive hospital has the best quality. The difference in price between them is almost $12,000, or more than 300 percent.

Now, this is real money, real unnecessary costs for her employer and eventually for the country. What does she get for the bigger bill? Lower quality care. Fortunately, we have found that, when given data on price and quality in a user-friendly way, consumers use it to make smarter health care decisions. When they do, they and their employers save money.

With these benefits in mind, I believe strongly that we need to do much more as a Nation to bring transparency and competition to health care so that the health care system can deliver better value to consumers. We must start by unleashing the cost and quality data that we already collect.

First, all purchasers of health care should have unfettered access to their claims data, which are their receipts, to enable price and quality transparency initiatives.

Second, all payers should be required to submit claims to publicly available, privacy-protected data repositories for quality measurements and reporting.

Third, the Federal Government should relax qualified entity restrictions on access to Medicare data.

Fourth, Medicare, which is the biggest payer in the United States, recently released prices for 130 procedures. That is great, but it should do the same for the more than 1,000 additional procedures in its database.

Fifth, Medicare should make physicians' quality data widely accessible. The anticipated release of this data has already been delayed by half a year.

Finally, all States or the Congress should pass measures that prohibit health plans and providers from entering into contracts that prevent disclosures of providers' price and quality.

By taking these small but bold and meaningful steps towards more transparency, you will all go a long way to bringing market discipline and better value to the American people.

Thank you all for the opportunity to speak with you. It is an honor and a pleasure to be here. I will be happy now to answer all your questions.

The CHAIRMAN. Thank you very much, Doctor.

[The prepared statement of Dr. Colella appears in the appendix.]

The CHAIRMAN. I will start with you, Mr. Brill. You mentioned that you outlined the problem by exposing the chargemaster phenomenon, but you also said the ACA does not really solve it. There are a couple of ideas here, and maybe there are a couple of provisions that might help a little bit, the Cadillac tax for one. But your thoughts? You have thought a lot about this. What is the solution here? We hear that transparency disclosure alone may not be sufficient. So, your thoughts?

Mr. BRILL. Correct. Thank you for the question. I guess what I meant by that is that it seems counterintuitive to me, if the issue is high prices and the issue is the market power of the providers who are able to charge the high prices, that injecting more competition into the entities that have to pay the prices, the insurance companies, is going to help things.

I mean, if you take the New Haven, CT area, where Yale New Haven has bought up pretty much everything, if you are an insurance company and you want to sell health insurance in and around that area, you have to pay whatever Yale New Haven is going to charge.

Now, the result of that happens to be that the head of the hospital makes 160 percent of what the president of the university makes. That is just a world that is upside down to me. I do not think that a tax on insurance premiums or a lot of the other efforts to inject more competition into the insurance market deal with that fundamental issue, which is that the price of everything is just way too high.

Now, as a journalist, my theory about why that was not attacked with Obamacare was that, if you do not mess with the profits of the key players in the industry, you get to get your bill through Congress. To me, that is what happened.

The CHAIRMAN. So you are basically suggesting that transparency alone is insufficient because many of these hospitals have such great market power.

Mr. BRILL. Hospitals have market power, the drug companies have market power. That guy needed that cancer drug.

The CHAIRMAN. Right. So what do we do about that? Let us assume for the sake of discussion that that is accurate. That is, there is very significant market power. In fact, I saw an article in one of the papers just a week ago that made that very point that you are making, that the drug companies have market power that al-

lows them to charge higher prices than what most people think the charges should be.

What do we do about that? Just quickly, then I am going to ask the others that same question.

Mr. BRILL. All right. Very quickly. I think there is another area of transparency, with all due respect to the members of this committee, we need to look at when we wonder about why those issues are not dealt with legislatively.

Since 2007, the health care industry has contributed over $32 million to the campaigns and PACS of the members of just this committee, with it split basically evenly on both sides the aisle. The member receiving the least got just over half a million, and the member receiving the most got over $2.5 million.

Maybe, in the interest of transparency, reporters covering hearings like this ought to list the contributions whenever an elected official holds hearings like this or votes on issues like this. Maybe even C-SPAN could put it as a chyron under each member's name, how much money they got.

The CHAIRMAN. Well, a lot is being disclosed these days, which is almost all good. But putting that issue aside for a moment, you are still suggesting that a concentration of market power is the essential problem here and the effect of which causes these high prices.

Mr. BRILL. Well, in part it is concentration, in part it is that it is not a market. In other words, no one buys health care voluntarily, with the exception of maybe plastic surgery, maybe Lasik surgery.

The CHAIRMAN. My time is expiring. I would like you to answer, if you could, Dr. Delbanco.

Dr. DELBANCO. So Catalyst for Payment Reform held a national summit on provider market power last week in Washington, DC, and Paul Ginsburg was one of our expert speakers, so I think we can both comment on this. Market power certainly enables providers to not be transparent about their prices. It also enables them to charge higher prices, and many think that price is the leading driver of health care costs right now.

So, when you think about the role of price transparency in trying to enhance competition among providers, if you are a purchaser like the members of our organization and you do not know what the price differences are across your choices, or as a consumer you do not know, you may mistakenly believe that higher prices are higher quality.

If we have greater transparency in both cost and quality, then I think we can come up with all kinds of benefit designs and networks of providers which people have access to that are higher-value options. Our members are beginning to experiment with this. There was the reference pricing example; there is the tier network example in Massachusetts where the State has cut out some of the highest-priced providers.

The CHAIRMAN. Right. Very quickly, let me just ask the others, is reference pricing a good thing? I know it is not going to solve everything, but is that something that makes some sense? Does anybody disagree with that?

Dr. GINSBURG. No, I think it is a good example of how to change a benefit design so that consumers, for the first time, care about which provider they go to. In a sense, a lot of the provider market power comes from the fact that the typical insurance that people have leaves the patient indifferent about which provider they go to, the very expensive one or less expensive one.

I think the challenge is to not raise deductibles so much. They focus on whether to get care or not, but within the context of a benefit design, saying you will pay less to go here. Even in New Haven, CT, where, as Mr. Brill mentioned, there is just one hospital, I am sure there are some freestanding outpatient facilities, physician offices, that provide MRIs and offer colonoscopies.

So in a sense I do not think there are that many areas where there is absolutely no competition, but the key thing is for people to have incentives in their insurance that get them to think about this issue.

The CHAIRMAN. Thank you. My time is way expired.

Senator Hatch?

Senator HATCH. Well, thank you, Mr. Chairman.

Mr. Brill, I have followed you for years, and I have a lot of respect for you and your tough reporting.

Mr. BRILL. Thank you, sir.

Senator HATCH. There is no question, this article is very, very tough. For years, though, we have known that our health care system lacks transparency and that the uninsured and under-insured do receive staggering health care bills. So why write this article now? What is different now, say, than 5 to 10 years ago?

Mr. BRILL. Well, maybe I am just late to the party. It could be that.

Senator HATCH. No, I want the real answer.

Mr. BRILL. Well, that is part of it. The other part of it is, I think, when you look at something, as I did, that is rapidly approaching a fifth of our economy and is so much now a part of people's lives because deductibles are higher, co-pays are higher, and everything else, it begs to be looked at.

I mean, I guess I can put it to you this way. I remember listening to a debate on one of the cable shows about, should we pay a million dollars to pay for the last 6 months of life of a terminal patient? It is an anguished debate, a really hard question. The way my mind works, I kept saying to myself, why does it cost a million dollars? Who is getting that money?

It turns out that, when you look at it, it is this alternate universe where the hospital CEOs are all rich, everybody who works in a hospital makes a lot of money, the drug companies' profits are higher than Apple's and higher than the software companies that we all admire, ambulances have become a private equity play. Something is going on here.

So it is a combination of a market that is not accountable, the regulations are not doing what they are supposed to do, and the incentives are not rightly placed. I think all my colleagues here have all the right answers, because we need multiple answers.

Senator HATCH. And I think most of us realize we are not doing what we should do, either. I mean, there have to be some changes

in the Congress as far as getting this under control. But I appreciate your testimony.

Dr. Ginsburg, I have great respect for you as well, and for all four of you. I think this has been terrific. I compliment the chairman for having you all come. But, Dr. Ginsburg, I am interested in your thoughts surrounding how we move forward in providing better information for consumers.

I am concerned that policymakers have focused too much on the amount of information to make available rather than the reliability and the usefulness of that information. Where should we focus our efforts in making sure that the right information is being released?

Dr. GINSBURG. Senator Hatch, I believe the best opportunity to inform consumers on issues of value is through insurers and employers. I think what government can do is, sometimes, provide the raw materials for insurers and employers to make their calculations so that they can draw on the experience of Medicare in doing that, but I think that this production of information is something that has to be customized to consumers; it has to reflect the details of their particular health plan. I think insurers and employers are best positioned to do that.

Senator HATCH. Thank you.

Dr. Colella, in your testimony you state that your company has an 80-percent take-up rate among enrollees. Now, that strikes me as incredibly high and frankly a little hard to believe. Are initial enrollment activities, such as simply signing up for coverage, included in this percentage?

Dr. COLELLA. Yes, Senator. Well, sorry. Can you repeat the question? I want to make sure I understand it.

Senator HATCH. Yes. I am concerned about, in your testimony you stated that your company has an 80-percent take-up rate among enrollees.

Dr. COLELLA. Correct.

Senator HATCH. That does seem to be awfully high to me. I find it a little hard to believe as well. But are initial enrollment activities, such as simply signing up for coverage——

Dr. COLELLA. Oh, no. Absolutely not. Sorry.

Senator HATCH [continuing]. Are they included in that percentage?

Dr. COLELLA. No. We are very proud of our uptake. Yes, we focus, in our company, a lot of resources to making sure that engagement happens. In order to do that, we have built an entire product team around consumerism and understanding how consumers use applications.

I joke about the fact that, when we started the company, everybody we hired in product actually did not come from health care, because we wanted people who really understand how consumers engage with technologies like ours. So the 80 percent, which is not with every employer but across the board is around those numbers, is a number we feel very proud of and has nothing to do with the enrollment in the health plan. It is the enrollment in the Castlight system.

Senator HATCH. Well, thank you.

Mr. Chairman, I have one more question for Dr. Delbanco. We have heard from hospitals that chargemasters do not matter and

that attention should be placed on the rates negotiated between providers and insurers. If chargemasters are only marginally relevant, what steps should be taken to move away from the system entirely, and what should replace it?

Dr. DELBANCO. That is a great question. Well, I think one of the most valuable things about CMS releasing the hospital charge data is, it was a great education for all about how much variation there is, even in the charges, much less the payment amounts, and the fact that the charges really have little to do with what people end up paying.

What we need to work toward, and it is going to take a lot of work and a long time, is understanding exactly what the underlying costs are of delivering care and what cost it takes to deliver high-quality care. Without having good information on both of those fronts, many hospital systems, health care systems, really do not know what it takes in terms of the cost to deliver a unit of care. If we do not know what that is, it is going to be very hard to come up with a rational system of deciding how much care, a procedure, should cost.

Senator HATCH. Thank you to all four of you. We really appreciate this panel.

The CHAIRMAN. Thank you, Senator.

Senator Thune, you are next.

Senator THUNE. Thank you, Mr. Chairman. I want to thank our panel today, too, for some really good insights. Mr. Brill, thank you for shining a light on this with your lengthy piece and all that it told us about what is going on in the health care business and how it impacts real people who are looking for health care services in our country today.

I want to ask the question, and I guess I would direct this to Dr. Delbanco, on the issue of price lists and hospitals posting prices for common procedures. We have in the State of South Dakota the South Dakota Health Care Organization that is responsible for compiling a price list of the 10 most common procedures in their, what they call a price point system.

I am curious to know how effective those types of listings are in using market forces to put downward pressure on prices, and really do consumers use those? In your experience, do consumers use those types of price listings to make choices about elective procedures?

Dr. DELBANCO. Thanks for the question. I think we know very little about whether consumers use that information. There are many States that are posting information of a variety of types, and there is very little research on whether consumers use it.

I think posting that information is the beginning of a process to identify how the market is working and the variation across providers. It is a step in the right direction that says that transparency is something that we are moving towards, but I do not think that posting a short list of prices is that relevant.

If you do not connect it back to the consumers' insurance plan, what their account balance might be in their insurance plan, what is in network or out of network for them—so it really takes a serious amount of customization, which States like New Hampshire

and Massachusetts have been working toward in their public websites, for it to really be usable by consumers.

Senator THUNE. Good.

Dr. Ginsburg, the conversation on reimbursements in the last couple of years has focused on the integration of health care and coordination of care. This may be providing an incentive in the market for consolidation. I am wondering, what role does consolidation play in pricing? As the landscape of health care providers changes, what areas of antitrust need to be reevaluated, if this trend continues, to help put downward pressure on prices?

Dr. GINSBURG. Yes. Well, I believe that the reforms in provider payment are leading to additional consolidation. I think there are a lot of other forces pushing for more consolidation as well. I think that the best approach is to take steps that make markets more competitive despite their consolidated state.

I think an antitrust policy is probably a need to revisit the safe harbor policy that the Federal Trade Commission has had to actually require demonstrations of benefits for patients from safe harbors. I think that the governments can take steps which can facilitate tiered approaches.

When Chairman Baucus asked about reference prices before, I neglected to say that I believe that most insurers or employers will not be capable of adopting a reference price system because of the likely push-back they will have from providers, who will basically say, if you have that, I will not contract with you. I think that legislation is important to outlaw non-competitive contracting practices between health plans and providers.

Senator THUNE. I would just ask this as a general question for anybody to answer. But, Mr. Brill, you talked about market power. One of the things that we are seeing with this consolidation and the integration is, as more and more physicians and hospitals are coming together, the entities are getting larger. I am just curious, sort of as a philosophical question, what can be done to return principles of the free market into health care pricing in this country?

Mr. BRILL. Well, I am not sure we ever started from that place, but we certainly have slid very far away from it.

Senator THUNE. We have evolved.

Mr. BRILL. Again, one of the things I found in doing the reporting is, if there is one countervailing power to even the most concentrated health care provider, it happens to be Medicare, which I found does an awfully good job. It is run, by the way, mostly by the private sector. It is contracted out. I thought that Medicare demonstrates that, if you have one really big buyer in the marketplace, it can serve to address the power, the accumulated power, of the providers.

Let me just add one thing, though, about the chargemaster. I know that there is a lot of response that, well, the chargemaster is not really relevant because it is only X percent of people who actually end up paying that. It happens to be the poorest people who are asked to pay it.

But the reason I focused on the chargemaster is, it is sort of a metaphor, if you think about it, for the whole health care system, in three ways. It is irrational. We all would agree with that. It is

completely unaccountable. Nobody can account for it, and no one can explain it. And the prices are just way too high. It serves as the basis upon which almost everything else in the health care system has to operate. The insurers negotiate discounts off it; everybody refers to it.

So, if we are talking about market power, the one entity again that is big enough to just literally brush the chargemaster aside and say, we will not even talk to you about that, is Medicare, which does a very good job as a consumer of health care.

Senator HATCH. Senator Brown, you are next.

Senator BROWN. Thank you, Senator Hatch.

Thank you all. This has been very illuminating, I think, for all of us.

Mr. Brill, thanks for helping to change this debate. You are a terrific journalist, because you tell stories so well. I want to sort of tell a story and ask you to comment on it. A couple of years ago, for a period of several years, there was a progesterone used by injection, taken by injection, for 20 weeks, once a week, for women who were at risk of low birth weight babies, of early births. So it was a progesterone called 17–P. The injection cost between $10 and $20 an injection. A woman would take, as I said, once a week for 20 weeks.

In February of 2011, a St. Louis company, KV Pharmaceutical, became the first company to receive FDA approval. This had been clinically tested earlier, the progesterone 17–P, by KV Pharmaceutical out of St. Louis. It spent about $200 million, went through the clinical trials, then began selling the drug and marketing it under the name of Makena and selling it for $1,500 a shot. So the cost of treatment went from $200–$300 to $30,000, an increase, if our math is right, of some 14,000 percent.

The CEO of KV said, well, it does not matter that we are charging this much. What matters is the savings that we provide for the health care system because there are not these very, very, very expensive dollar costs and human costs: early births. How does this happen? I mean, how does this health care system allow this to happen, where they can come in like this and disrupt something that was working well, there is no argument there, and take this much money out of the health care system?

Mr. BRILL. Because they can. Again, there is not a competing drug, I take it, from your story.

Senator BROWN. Well, there is, but not the competing market power, because they both are out there now.

Mr. BRILL. Let us even say there is sort of a semi-competing drug, but it is the physician who prescribes the drug. The physician may have consulting contracts with the drug company; there could be all kinds of things going on. But I think your story just demonstrates again—and there are a thousand stories out there—that this is not a marketplace that functions like other marketplaces.

Name a product outside of health care where the price can go up one day by 1,000 or 10,000 percent just because it can. I guarantee you, without even knowing the price of that drug, if it is prescribed in every other developed country of the world, it did not go up that high and is not that high.

Senator BROWN. That is correct, yes.

You call the current drug reimbursement structure a perpetual gift to the pharmaceutical industry. A number of us here have suggested that Medicare negotiate drug prices. Give me your thoughts on that.

Mr. BRILL. Well, I am not an expert on that or anything else. It just seems logical to me that if you are the biggest buyer of something, you ought to be able to negotiate the price for it. The resulting loss to taxpayers—the math is pretty clear. It is a big loss; it is pretty high. So it is a question that almost answers itself, it seems to me.

Senator BROWN. Could the rest of you give us your thoughts on, as we do in the Veterans Administration, giving Medicare the ability to directly negotiate drug prices on behalf of X million consumers of those drugs? Dr. Colella, if you would start first.

Dr. COLELLA. Thank you for the question, Senator. I am not an economist, so I do not really have a strong opinion on that. It just seems completely logical that if you are the biggest payer and you are paying for something, you have the power to negotiate for it, and that gives you market power and allows you to reduce the cost.

Senator BROWN. Dr. Ginsburg?

Dr. GINSBURG. Yes. Actually, the Veterans Administration is very successful because they have the threat that they will not include a drug on the formulary. In a sense, they can get therapeutic alternatives to compete for the right to sell to the VA. I think if Medicare is going to take that approach, you are going to have to be ready to answer the complaints about, well, but I wanted this drug, and you negotiated for this drug instead. Now of course you can go to a pure regulatory system and just say that we are going to set drug prices for everything, and we are going to include them.

Senator BROWN. I do not hear those complaints from veterans that their drug is not available, not on the formulary that has been negotiated or that has not been negotiated, so why would we hear them on Medicare?

Dr. GINSBURG. Well, I think the reason is that, in the Veterans Administration and Kaiser Permanente, they involve their physicians in these choices. So, in a sense, if the physicians help make the choices and explain to the patients why this drug is good, I think it is much less likely that complaints like that would come up.

Senator BROWN. Dr. Delbanco?

Dr. DELBANCO. I would just say that I am excited that we are finally approaching an era where we look at the comparative effectiveness of different therapies, drugs, procedures, and that, as that information becomes more available, I certainly hope that the Federal Government will act on it.

So, as we think about purchasing drugs, there should be some kind of system where we are purchasing based on the value that they offer. Whether that involves a competitive bidding process or other process, I will not comment on, but bringing into account how helpful, useful, and valuable the different therapies are will be really important.

Senator BROWN. I wish we were, as you said, moving into an era of comparative effectiveness, because it was labeled rationing, socialism, every other negative descriptive term imaginable in that

debate, and was not really included the way that it should have been here.

The CHAIRMAN. Thank you very much.

Senator Bennet, you are next.

Senator BENNET. Thank you, Mr. Chairman.

I will actually pick up where my friend left off in talking about socialism, and who is the biggest Bolshevik, and all this other stuff. [Laughter.]

I want to say that one of the great mysteries to me about this place over the last 4 years has been why this health care debate has been so partisan in this town, because the people whom I represent, their prices are going up, the quality is not improving. That is what they care about. This place has made a mess of all this, in the discussion that we had.

So I want to thank you, Mr. Brill, for your article, first of all, which I think reveals very clearly that there is no market, because there is no price transparency for anybody. I hate to use the word, because it sounds like a 50-cent word, but, when I read your article, my main reaction to it was that opacity should never be a business model. But it is a business model for the folks who are delivering this stuff.

So the first question I had for you was, I would be curious to hear what the reaction has been to your article, what you have heard from people in the industry that you wrote about, and what they have said to you about the content of your piece. There is nothing defensible about the chargemaster.

Mr. BRILL. And they actually have not tried to defend it, except to say that it does not matter, to which one might ask the question, well then, why do you have it if it does not matter? I think, rather than generalize, I will point out one thing that kind of surprised me about the reaction.

That is, I had written in the piece that the nurses and most of the doctors, unless they were gaming the system in some way by getting consulting contracts, the people who actually provide the care are not on the gravy train that everybody else is on.

What surprised me in all the mail I have gotten is that, not only have they not made out as well, but they really feel like victims of the same system. They feel, not only that all these other people are getting wealthy while they are doing the scut work—which is not scut work, it is saving people's lives—they feel like they have no control and they are demeaned by the whole system, whether it is jumping through hoops to fill out insurance forms or everything else.

As one doctor wrote me, he got an angry memo from his supervisor that he had ordered in the last quarter 3 percent fewer tests than he had the quarter before, and he had better get that rate back up, as if the patients obviously must have needed more tests that he did not order.

So that, to me, is the most surprising reaction, that the most important players in the system, the people who provide the care for all of us, are not only not the beneficiaries of the system that you describe as so opaque but are, I think, the victims of it too.

Senator BENNET. So I would like to ask the doctors, before they roll me out of here, what would be your top one or three or what-

ever the number of things that could be done administratively today that do not require us to get our act together in the Congress, but could be done today by CMS or anybody else, to drive the transparency that we are talking about.

Dr. DELBANCO. I would echo something that Dr. Colella said about CMS releasing more data and allowing it to be used by more qualified entities to analyze for quality and payment patterns. I think that is the number-one thing that I would add.

Dr. COLELLA. Yes. Thank you very much, Suzanne. It is of paramount importance. CMS is sitting on so much data; it is a gold mine. Making that data accessible will help everybody understand much better the quality of care and the cost of care.

Last but not least important, is also making sure this is an easy thing to do, and it would go a long way toward solving problems, making sure that people who pay for health care, which are mostly the employers, have access to their claims. A claim is a receipt. When you go to a store and you buy something, you have the right to have that receipt in your hands. It is just incredible that it is only in health care where this does not happen.

Senator BENNET. But even then, Doctor, the best that people can do is maybe figure out what they have been charged—maybe. But we never can get to what it actually costs. You mentioned colonoscopies earlier. I mean, the range in communities is——

Dr. COLELLA. Thank you, Senator. That is exactly my point. Once you have the claims, that claim then can be given to organizations like ours or like other public organizations that know how to actually explain to the consumer what they will be charged out of pocket.

I think Dr. Ginsburg pointed out very, very appropriately that to just show a price does not mean we can tell people what you are going to pay for your colonoscopy out of pocket, and where you are going to get that colonoscopy. And you know what? If you go to the hospital next door, you may pay half and have the same doctor. That is shocking.

Senator BENNET. I am out of time, but I think Mr. Brill had a comment.

Mr. BRILL. Yes. I just want to add, on the subject of information, this could be a whole other hearing. But, as I started to try to get information about Current Procedural Terminology codes and all this stuff, I found out that, somewhere along the line, that CMS and the Federal Government have given certain information and licenses to codes to the American Medical Association, the American Hospital Association, and they started asking, well, are you working for a for-profit company, what are you seeking this information for, why do you want it? I know there is a reference in your testimony, Dr. Colella, about them requiring that this data, which is our data, the taxpayers' data, cannot be used by for-profit entities but only nonprofit entities, such as nonprofit hospitals, for example. That should be a whole other hearing, because there is a real issue there.

Senator BENNET. Thank you, Mr. Chairman.

The CHAIRMAN. I just want to ask one question of anybody. What is the responsible—if there is one—argument why CMS should not release all this data, whether it is doctors' charges or hospital

charges? What is the rational, reasonable counter-argument, if there is one? Why don't they?

Dr. GINSBURG. Yes. I would like to point out the difference between that and information about quality, about practice patterns. That, I think, would be very valuable for CMS to release. Medicare Compare is probably the single-most important source of quality information for those seeking to——

The CHAIRMAN. What is the answer? What would CMS say if we said, all right, CMS, release it all? Would they have a counter-argument?

Dr. GINSBURG. I do not know, but I was going to make the distinction between——

The CHAIRMAN. Well, I am asking, can anybody indicate what maybe CMS might say?

Dr. GINSBURG. The only thing I could think of is, I do not think there is a person in this room who has a computer with the server capacity to be able to receive it.

Dr. COLELLA. Well, no, there is also another argument to be made. Very powerful provider organizations do not want this data to be released. So, when we, as a known qualified entity because we are a for-profit, which the last time I checked was not a crime in this country, asked to have this data so we could work on it to show quality measurements, we were told, no, you cannot because you are a for-profit organization. The reality is, people do not want to be held accountable for the quality of care that they deliver.

The CHAIRMAN. So I would just be honest, I have not heard a good, solid answer.

Dr. GINSBURG. There isn't one.

The CHAIRMAN. All right.

Senator Wyden?

Senator WYDEN. Thank you, Mr. Chairman. I believe the answer to your very good question, Mr. Chairman, is there is no answer. Later today, Senator Grassley and I, apropos of what the chairman has said, and Senator Bennet, are going to introduce legislation to open up the Medicare database. This is long overdue, and I appreciate the thumbs up. Let the recorder note that one of the witnesses gave a thumbs up to that.

This is a treasure trove of valuable information. It needs to be released in a way that is sensitive to protecting the personal issues with respect to seniors. But, in answer to the chairman's question, there is no reason for not making this public.

I want colleagues to know Senator Grassley and I are going to do everything we can to add this to the SGR bill, because I think it is very appropriate, apropos of what Dr. Ginsburg has talked about, that we get this information.

It is going to give us a lot of clarity with respect to practice patterns across the country. For the first time, people around the United States are going to be able to see what Medicare actually reimburses for various services.

People have been debating this since the days when I was co-director of the Gray Panthers, but I think the answer to the chairman's question is, there is no compelling reason for not doing it. With the court's decision as well, I think we now have the green light to get it done, so I thank you all for your answers.

Let me ask you about one other area, and that is, my hope is, in the days ahead, we will be able to also focus on an area of Medicare that has been neglected in the past—and Senator Casey and a number of colleagues, Senator Isakson, have been talking about this—and that is chronic disease. This is where most of the Medicare money goes.

Well over 80 percent of the Medicare money in America goes to heart, stroke, cancer, and diabetes. I would like to have you all outline how you think access to data and improved transparency in the Medicare program in particular can help identify and help treat seniors with chronic disease.

So why don't we start with you on that, Dr. Ginsburg?

Dr. GINSBURG. Thank you, Senator Wyden. I believe that the best approach to addressing chronic disease is not publishing a lot of data, but to reform the provider payment system, such as through Accountable Care Organizations or similar things.

These are organizations that are accountable, they have incentives, and their biggest opportunities are to address chronic disease better than in our fragmented fee-for-service system. So I would not go the transparency approach, I would go the payment reform approach.

Senator WYDEN. Well, I think, Dr. Ginsburg—you are an authority in this area. My hope is, we could do both. We could do both, and certainly the Accountable Care Organizations, in terms of integrating care, move us in the right direction.

There are some issues, particularly the attribution rule, that I hope—and we will have another nod for the recorder, because Dr. Ginsburg helped us there as well. I think that the attribution rule is also limiting our ability to see practitioners specialize in chronic disease. If you would like to follow that up, please.

Dr. GINSBURG. Yes. Yes, I would. I mean, I think, even though there is a lot of potential in Accountable Care Organizations, the specifics on which the legislation was written and the regulation was written may not have been the best calls.

I would like to note that the Bipartisan Policy Center, when they came out with their strategy, they called for an enrollment model of Accountable Care Organizations where beneficiaries would have incentives to enroll, and that that would be a big improvement in attribution over the way it is done now.

Senator WYDEN. Well, you are absolutely right that there are a number of pieces to this puzzle. There are also some questions about which vulnerable seniors are going to get access to a care plan, because the language in the text of the rule talks about people at high risk. One of the things that has come to light is what happens to people who, say, have three chronic conditions. Are they considered high-risk?

But for any of you, on the point of transparency and chronic disease, what are your thoughts with respect to how various transparency reforms that you have been talking about can help us deal with the area that I think Medicare has been transformed into? There is more cancer, more stroke, and more diabetes than when Medicare began in 1965. Having your thoughts about how transparency can help us tackle chronic disease, Doctor, would be great.

Dr. COLELLA. Yes. So I have been a practicing physician for many years. I think Dr. Ginsburg is right: transparency is not the only solution. Transparency is the beginning. The way I like to say it is, transparency is like giving you a great seat to a very bad movie. We are just starting from there.

But transparency is not only transparency on prices, transparency is transparency on quality. So Medicare can give us data, and, the more data we have, the more we can pick quality. When my mother had cancer and I really desperately wanted to find a good, quality hospital for her cancer, I could not figure that out.

That is an area where Medicare really is still lacking, and it is not fair to American citizens. As a physician, I find this almost offensive, the fact that we cannot understand who is performing better, what are the better outcomes, where do we get the best surgery, and ultimately, what are we paying for?

Senator WYDEN. My time is up, Mr. Chairman. But again, I am surely glad you asked that question about the database.

The CHAIRMAN. All right.

Senator Nelson?

Senator NELSON. Representing a State like Florida where a high percentage of our population is elderly, it is not infrequently that I get the panicked call to one of our Florida offices from a senior citizen with, for example, what happened last week, a bill from the hospital of $40,000. When we got into it on behalf of the senior, what was worked out was a bill of about $4,000. So it basically is another example of the thesis of your article.

Now, beyond that, I am concerned, as we implement the Affordable Care Act, and we are seeing, at least in Florida, hospitals buying up doctors' practices and other health care provider practices since we set up Accountable Care Organizations under the bill—and we want to encourage physicians to get together in order to get efficiencies of scale, sharing of information about patients, therefore elimination of duplication—whether this is a good thing to promote.

Here is what is happening, and I would like your comments. Hospitals are buying the doctors' practices, then a patient in a doctor's practice in an ACO not owned by the hospital has an emergency. They end up in the hospital. Whatever the problem is, it is taken care of, and now they are ready to exit the hospital and they refer them to one of their doctors' practices that the hospital owns, and in some cases their original doctor does not even know about it, is never informed, and is cut completely out of the loop.

Now, other than stealing patients, which this system would lend itself to, it clearly is a way of consolidating power by whoever owns all of the medical services. Now, this is contrary to the competition that we were trying to create in Obamacare. Can you all comment, please?

Dr. GINSBURG. Sure. I would be glad to comment. I think the pressures on physicians in small practices to change, either to become employed by a hospital or to perhaps join a large physician organization, are very intense now.

I believe that if they could join physician organizations, whether they are medical groups, independent practice associations—which are looser organizations which have had success in California and

Massachusetts—that makes the market more competitive than when hospitals employ physicians.

So I think it is an opportunity for insurance companies and for governments to take steps to foster and encourage the development of physician organizations. I think the medical profession would rather that be the result than that their members all work for hospitals.

Senator NELSON. Well, that is the theory of the ACOs.

Dr. GINSBURG. That is right.

Senator NELSON. But what is happening is consolidation of the hospitals—exactly the opposite.

Dr. GINSBURG. That is right. Well, ACOs——

Senator NELSON. So what do we do?

Dr. GINSBURG. The ACOs can be led by hospitals, they can be led by physician organizations, or they could be exclusively a physician organization. I was actually very pleased with the most recent announcement by CMS at the beginning of this year about its new ACO contracts, that a majority of them were for ACOs led by physician organizations, and they have in fact eased some of the requirements for physician organizations to contract with them for ACOs.

So I think, if you can think back to the 1970s, the Federal Government did a lot to foster the development of health maintenance organizations. There may be an opportunity for the Federal Government to foster development of physician organizations.

Dr. COLELLA. I could just give you a personal experience. As a physician who practiced, I saw two things in the 1980s when there was another wave of consolidation to take capitated contracts. The model of physicians employed by hospitals is a business model that usually does not work. You usually create low-handicapped golfers at that point, because you take away the incentive to work harder.

While I totally agree with Dr. Ginsburg that this is an opportunity, if we have physician-driven organizations that compete in a free market and competition is based on the common denominator of transparency on quality and price, you will have a much more efficient market, and costs in every free market come down. I would ask anybody to show me a market where it is a free market, where there is competition, and we have not seen prices come down.

Senator NELSON. I do not know how we would do that if, in a given urban market, the hospitals are owning most of the practices.

The CHAIRMAN. Thank you, Senator.

Senator Burr?

Senator BURR. Thank you, Mr. Chairman. I am shocked at what Senator Nelson has uncovered, that providers would do exactly what we designed and take advantage of it. I might say that Blue Cross Blue Shield has experimented in Florida with actually owning their own provider networks, doctors, and the insurer, cutting the hospitals out.

So to say that everything emanates good from up here, there are experiments going on in every community across the country. I remember when Safeway was that model up on the pedestal that we all looked at and said, gee, look at what can happen. But I will get to that.

Mr. Brill, your article was very informative.

Mr. BRILL. Thank you, sir.

Senator BURR. It has been diluted to some degree. I have to tell you, in full disclosure, I have taken health care money. I do not know how much; I cannot tell you from whom. But I think it is a cheap shot to come in here and say that has contributed to the health care model that we have today. I do not think any members have written more reform legislation than Dr. Coburn and I, and we have never been influenced by where we took money from.

Mr. BRILL. It would be a cheap shot, if it is what I said.

Senator BURR. I think it is a convenient excuse some people use, but there are many members who take it seriously up here.

Dr. Delbanco, will Safeway's model be able to exist with the Affordable Care Act?

Dr. DELBANCO. There have been questions about the annual out-of-pocket max, how much consumers are going to be spending out of their own pocket, and the cap on that, and whether or not you can still have a reference pricing model with that cap in effect.

There are some health insurance companies that are moving full steam ahead, saying yes, we think that there is still plenty of financial incentive within that maximum amount we want consumers to spend out of pocket to encourage them to seek care for more affordable choices.

Senator BURR. But if their model does not check all the boxes—well, they are grandfathered, right?

Dr. DELBANCO. Who?

Senator BURR. Safeway. Are most of the large corporations that make up your group grandfathered from the Affordable Care Act?

Dr. DELBANCO. I have not done a poll of all of them to know exactly which position they are taking.

Senator BURR. All right.

We have had a lot of talk about Medicare. Let me just suggest that I think we have made great strides when we instituted Medicare Part D. We thought about it from outside the box, I think. We created an insurance model. Yes, we did not go as far as to say the Federal Government can go out and do what the VA does, but what we found was a marketplace that reacted even better, I think.

In many cases, our projections on what the cost was going to be for risk-takers to provide certain structures or formularies actually has come down, in large measure because generics were used, in other measures because patent lives expired and we had some of the blockbuster drugs go off of patent.

But what we found was that we had a more positive cost experience than what we had designed. The one thing that we learned from that that we did not anticipate was that seniors do not like choice. When given a choice between something and something else, it was hard to make a decision.

I think, at the end of the day, the person who most served as the navigator for a senior was a child, not a health care professional. This should be alarming. Even as one who had 19 years in policy, it was tough for me to try to determine how to navigate for my parents.

Let me suggest to you that part of our health care reform has to be putting health care providers back in the consultation and de-

cision role, and I think, Dr. Colella, it gets at the heart of what you talked about, which is tying cost and quality together, if I remember.

If we do not judge quality, then cost is an irrelevant thing. It is either affordable for somebody or not. Part of the quality is going to come from the relationship between the medical professional and the patient.

Let me ask all of you, is there any value to us going back to a health care system that really resembles 30 years ago, when we got a service delivered, we paid for it out of our pocket, and then we were reimbursed when we filed back to our insurance company? Have we become so insulated as patients that we have no concerns about what the cost is, therefore we do not assess value because we do not know what we paid for something?

Mr. BRILL. I think that what I saw when I did my reporting, Senator, is that that has, in the last couple of years, changed a lot, where it is now relevant to everybody, because deductibles are higher, co-pays are higher.

I think where it is definitely the case—and you may recall I wrote about this—one of the patients who had $335,000 worth of bills, he was on Medicare, and his out-of-pocket expense was $1,139. He would just wake up in the morning and go to some doctor. He had a bunion, and it cost him 82 cents, but it cost the taxpayers $60, as I recall. So he had no skin in the game at all.

I think Medicare really needs to look at that from top to bottom. This man is basically upper middle class. He could easily have afforded more than 84 cents on the whim of having a doctor look at his bunion. But I think that all of us who go to doctors who are not in Medicare, we now have pretty much everyone who has a lot of skin in the game, which is why I think the reaction, frankly, to the article was much stronger than I expected, because everybody has a story now. Everybody has an experience.

Dr. GINSBURG. I want to point something out, that over the last 10 years, as Mr. Brill was mentioning, there has been a very substantial increase in the degree to which privately insured patients need to pay part of the cost of their care. That is continuing.

What is striking is the contrast with Medicare, because Medicare's benefit design has not changed, and supplemental coverage is just so common that your typical Medicare beneficiaries pays nothing at the point of service for care. I am not sure how long that divergence is going to continue.

Senator BURR. No, I agree with you. With the supplemental care, you can buy down any risk exposure, and that is not a good thing.

If I could, Mr. Chairman, just one last statement.

The CHAIRMAN. Very, very short, please.

Senator BURR. Over 10 years ago, I remember having a conversation with Mike Hash, who was then CMS Director. It was over a new technology called contrast imaging. The fact is, CMS had no code for contrast imaging. We went through months of the need to do this, because contrast imaging compared to non-contrast gave one greater clarity of the diagnosis. It is common practice today.

But I remember the day he called me, and he said, "We have a solution to the problem." I said, "What is that?" He said, "We are going to reimburse non-contrast imaging at the same number as

contrast imaging, and the two will just sort of work themselves out."

I was dumbfounded at the other end of the phone, that all of a sudden we had created a reason for every hospital administrator to become a crook because, if you eliminate the thing that has the best result from a diagnostic standpoint, you will tell them, only do non-contrast because, if it does not show it, we can do all these other tests and they will pay the bill.

I think what I have heard from all of you is that our health care system needs to be redesigned. It needs to focus on patients playing a large role in, not only their choice, but cost playing a big role and quality playing a big role in the choice.

Mr. Chairman, it is going to be a big task for us, but I think Medicare is the 800-pound gorilla in the room. When we are willing to reform Medicare as we know it today, I think we will have a private system that in fact follows.

The CHAIRMAN. Senator Casey?

Senator CASEY. Thank you, Mr. Chairman. We want to thank the members of the panel for being here, for your testimony and your scholarship. It is important that we get this right. One of the ways that we are going to get it right—and when I say "we," I mean both parties here and anyone who is interested in improving our health care system—one way we get it right is by trying to find the answers to difficult questions. Mr. Brill, your article reminded us why we have a free press, even when it makes us uncomfortable. But we are grateful for the work that went into that.

Mr. BRILL. Thank you.

Senator CASEY. I have a question that I am going to ask all of you, but I start with a line—I know it is not the best way to summarize testimony, but, Dr. Ginsburg, on page 3 of your testimony you say, "I perceive the greatest potential to obtain lower prices comes from approaches where purchasers and health plans, rather than report prices to their enrollees, analyze extensive data on cost and quality and provide their enrollees very simple incentives to choose providers determined to be higher value."

So you talk about analyzing data that would undergird the provision of incentives. Can you tell me why you made that statement and why you came to the conclusion that that is the best way to lower prices?

Dr. GINSBURG. Yes. Well, sometimes we look at examples where there are opportunities to lower prices. If somebody needs an MRI, we tell them that it costs less at a freestanding facility than in the hospital outpatient department. But there is so much of care that is not scheduled.

I think we might just use incentives like, we have assessed the different hospitals in this community, and we feel that this group of hospitals has higher value than the other group of hospitals, so we are just going to give you a lower deductible if you go to the preferred tier of hospitals.

I think there is a limit to the complexity that consumers are willing to deal with. You do not just give them a lot of price information when they are worried and sick; it is very complicated. So in a sense, I see a role of someone else digesting the information, and in a sense it is not a transparent approach, although I think it is

an effective approach, just to say, we have made a judgment as to which providers are higher value and, if you go to them, you will pay less.

Senator CASEY. So we come to that question of incentives. I wanted to ask each of you a question. I have 2 minutes, but it is a little bit of a lightning round. But Column A and Column B: Column A would be any provision in the Affordable Care Act that you think positively impacts this problem that we have discussed here today.

Column B, even if Column A has none—as I think Mr. Brill will say based upon your earlier testimony—even if Column A is no provisions, no positive effect, what should we be working on for Column B? What policies, just by way of itemization or listing of them? I will start with Mr. Brill and we will go left to right.

Mr. BRILL. Yes. I would just remind the Senator that I did write that there are a lot of very good, positive provisions in the Affordable Care Act, but they do not attack the price issue.

Senator CASEY. Right. But if you had to make your lists of steps we should take——

Mr. BRILL. Well, I tested one in the article. The more I think about it, and the more I have gotten reaction, and the more I do the math, the more I think it works, which is, if you lowered the Medicare age, you would actually save money compared to what it is going to cost us to fund the subsidies on insurance premiums under the Affordable Care Act.

Senator CASEY. You had that example of the 64-year-old, 11-month person.

Mr. BRILL. Yes. She would have saved money if she had been a month older, but actually the government, under the new regime, would have saved money.

Senator CASEY. Thank you.

Dr. Delbanco?

Dr. DELBANCO. So I would take it in a different direction and talk about how some of the new payment models that are being stimulated by the Affordable Care Act will help in this case, because, first of all, consumers do not know enough to know what individual components go into their care. If you look at the individual payments made under fee-for-service, it is unintelligible.

I think, whether it is bundled payment, global payment, or the new methods, they should be tied to quality performance, where it is not just, you get to earn more as a provider if you do well, but actually, you will take on some risk if you not only go over budget, but if you do not perform well on the quality measures. I think we could go a long way to creating incentives for all parties to not only choose higher-value providers, but for providers themselves to be higher-value.

Senator CASEY. We are out of time, so if you could itemize them quickly.

The CHAIRMAN. Go ahead.

Dr. GINSBURG. Yes. I would say that our premium credits do not depend on which plan you enroll in, so people have very strong incentives to get a lower premium. What we are seeing is a lot of innovation in network design and plans in response to that so that plans are not including the lowest-value, most-expensive providers

in their networks and the plans they are offering on exchanges. I think that is a positive change.

Senator CASEY. Dr. Colella, you get the last word.

Dr. COLELLA. I will try to make a long story short, which is really hard for me. People respond to incentives, and, if we pay doctors in a different way, with bundled payments like Suzanne was saying, or we provide data to consumers with incentives, we will actually see changes in behavior.

Senator CASEY. Thank you.

Thank you, Mr. Chairman.

The CHAIRMAN. Thank you, Senator.

Next is a very good friend of mine, a wonderful Senator, and today happens to be his birthday.

Senator ROCKEFELLER. Oh. That is me.

The CHAIRMAN. Senator Rockefeller?

Senator ROCKEFELLER. Thank you, Mr. Chairman.

I am struck, Dr. Ginsburg, by your present and previous position with the Independent Payment Advisory Board. I want to relate my question to the fact that the increase in prices is not just a problem for the consumers, but it is the underlying cause of the sustained growth of the cost of health care, which is growing faster than the rate of inflation. We cannot live with that, so we have to do some dramatic things.

I have always felt that fee-for-service built in an inefficient system, because it relied on others who did not have public judgment or a concept of fairness, or whatever, to make decisions. I refer you to the incredible battle we had with the health insurance industry, as much a layering on of lobbying and money if I have ever seen one. We had this thing called the public option. Everybody loved it. There was just one problem: we could not get any votes in the Senate Finance Committee. I tried it and got nine, Senator Schumer tried another one and got 10, so it was dead.

Everybody screamed and yelled that anything other than a public option was traitorous to the American people. So we came up in the Commerce Committee with something called a medical loss ratio. Nobody can understand what that means, which is key to calling up a bill if you are of good faith and good heart.

What that simply said was, it worked off the concept of Ingenix, which is my parallel to chargemasters. They work differently, but they controlled basically the same things, until they were brought down by an Andrew Cuomo-initiated court suit in New York and then by our legislation, that said they had to pay—it was sort of simple and brutal. They had to pay 80 or 85 percent, depending upon the size of their business they were insuring, or the number of people.

They had to pay 80 or 85 percent on health care that made people better, and then we were watching them because, if they did not do it, then they had to start rebating to the American people, and already the thing is only a year and a half old and several billion dollars have been rebated to the American people. People come up to me in West Virginia and ask, "What is this check for?" They will figure that out. I am trying to make a comparison again about fee-for-service not being good.

My answer to that in part is in fact IPAB, which is not wildly popular in either the House or the Senate. But it is in the Affordable Care Act, and I think it is a very good instrument, because it takes away from lobbyists, Mr. Brill, and takes away from Congress people, Mr. Brill, the ability to make a decision about how we reimburse Medicare, the largest of all spenders in health care, and puts in the hands of 15 people like yourself—Gail Wilensky, Stuart Altman, and the next generation, the next generation of those people—the sole power to make those decisions: how do you reimburse physicians, how do you reimburse big hospitals?

I mean, I have watched big hospitals buying up more little hospitals, and it is repulsive. It is an act of growth and not an act of better medicine. I like that IPAB system, because it controls costs, it is done by wise people who are not subject as easily to lobbying, because you already know it all, and you make wise judgments based upon the transparency of information, which I support.

But I also support the idea that you give consumers a lot of information, and sometimes it is distressing—I say this respectfully—to them or to me, how to make a decision from that.

But deciding how much people are reimbursed under Medicare—doctors, hospitals and others—is to me the most powerful instrument for the control of the cost of health care and, therefore, also obliterates this ridiculous situation which Mr. Brill reports, that the poor pay more than the non-poor in our hospital system.

Could you respond?

Dr. GINSBURG. Sure. Senator, the overall idea of delegating some authority to a committee or a commission of wise people to make detailed decisions where perhaps, in the absence of lobbying, they could make wiser decisions, I have always seen that as an attractive idea. I wrote an article about that a number of years back before the Affordable Care Act.

What I am concerned about is the way IPAB came out. Because many members of Congress were so reluctant to delegate their authority, IPAB's authority is so constrained and so limited that, really, pretty much the only tool it has is to squeeze provider payments, which is something that Medicare has been pretty good at. I do not think it needs the IPAB to do that.

Senator ROCKEFELLER. But it takes a two-thirds majority to override it, your decision.

Dr. GINSBURG. Yes. But I am saying, as far as hospital rates go, physician rates, they are on auto-pilot. Congress can always say they should be lower. That is what I mean. I think that the opportunities in Medicare to reduce costs long-term come in provider payment reform.

I am very enthusiastic about the vigorous piloting programs that the Innovation Center at CMS is running on ACOs, bundled payments, medical homes. I think that is where the future is as far as cost containment, as opposed to an IPAB which is limited—I think improperly—to just adjusting provider payment rates.

Senator ROCKEFELLER. I thought I threw you a softball, and you hit it all the way to the pitcher's mound, but I still think you are terrific.

Dr. GINSBURG. Thanks.

Senator ROCKEFELLER. Thank you, Mr. Chairman.

The CHAIRMAN. Thank you, Senator.

It is my understanding that, even though there is a wide variation among hospitals, say, for certain procedures—colonoscopy has been referred to several times—that there is much less variation in what Medicare pays around the country for that same procedure. I saw a chart somewhere. It is pretty flat around the country. It is flat-lined. There is not a lot of variation. The variation is much more in the private sector; it is not Medicare. If that is accurate, I would like to know why we have not yet focused on the variation in private pay?

Dr. GINSBURG. Yes, that is entirely accurate.

The CHAIRMAN. And then also, what data are Medicare and CMS going to release? Is it just with respect to Medicare reimbursement, or does Medicare also have the data on private pay charges?

Dr. GINSBURG. That is right. The Medicare payment rates do not vary much. Basically, all hospitals are paid the same for DRG except for the index of local input prices, and, if they are a teaching hospital, they get an extra amount for that, or if they are a disproportionate share hospital. But it is generally uniform, whereas private payments vary enormously.

The CHAIRMAN. I know. My question, though, is, what do we do about the private side, assuming that Medicare is doing a decent job?

Dr. GINSBURG. Sure. One thing that has not come up in this hearing is—we have talked about how to use competition to address some of the variation of prices on the private side—but nobody has mentioned the other alternative, which is to regulate those prices the way, say, Maryland has done for hospitals.

The CHAIRMAN. Could you explain that? What does Maryland do with respect to regulation of private payers?

Dr. GINSBURG. Yes. Well, Maryland, since the late 1970s, has been setting the rates that hospitals in the State can charge. It also sets——

The CHAIRMAN. Mr. Brill, what about that? Does that make sense?

Mr. BRILL. It seems to work. In a world of perfect information, I will tell you what the information ought to be. There ought to be sort of a 5-column price list for a hospital. One column is, what does Medicare pay for that; another would be, what does the chargemaster say—that one would be all the way over there—and then what do the three largest insurance companies doing business with that hospital, what do each of them pay?

So those would be your five columns. If you publish those five columns—and that is really kind of a summary of the work that Dr. Colella is trying to do in one respect—if you publish those five columns, those columns would start to come together very quickly, because it is just too——

The CHAIRMAN. What about quality? There is a lot of discussion here that just transparency alone is not sufficient.

Mr. BRILL. Well, I am describing there——

The CHAIRMAN. I am asking now about quality. What is the quality input in those columns?

Dr. DELBANCO. I think part of how you reduce payment variation is, you have much more transparency on quality. You start asking

your provider, justify to me that you are 40 percent better than that hospital down the street, and, if you cannot prove it to me based on quality, then I know where to go for a better value.

So I think the quality measures have to be those where there is the greatest disparity among providers, not just the quality measures that are the easiest to report and sort of the least offensive to providers. I think if we move toward those quality measures that really show differentiation, payment variation will reduce along with that.

The CHAIRMAN. How far along are we in measuring quality?

Dr. DELBANCO. We have many, many, many quality measures. I think the problem is, we have probably too many now and not enough that focus on exactly those points where there is the greatest opportunity for reducing harm if we improve quality and where there is the greatest variation in performance. We tend to measure things that are easy to collect data on and that show very little difference among providers.

The CHAIRMAN. So how would you synthesize or bring together these quality measures? What would you do?

Dr. DELBANCO. I would look to see where the greatest complications are, the greatest risk of mortality is, and where the greatest disparity in costs is. I would use those as the criteria for selecting a more parsimonious set of quality measures than the huge proliferation we have today of measures that do not help consumers very much.

The CHAIRMAN. All right. Thank you.

Senator Menendez, you are next. Thank you.

Senator MENENDEZ. Thank you, Mr. Chairman. On a day of competing hearings, I thought this was an incredibly important one to come to, but now that I know it is Senator Rockefeller's birthday, it is an extremely important one to come to. So Jay, happy birthday. Many more.

Let me thank the panel for their testimony. Mr. Brill, in your article, you make very little mention of health reform and how it could help resolve or mitigate many of the issues you discuss. For example, when you describe a couple who are faced with high fees related to cancer treatment, you say that "Obamacare does nothing to prevent the high costs."

Yet I would suggest to you, by limiting the low-quality mini-med plans which do not provide comprehensive coverage and expanding access to insurance that is required to provide standard benefits and meet specific quality standards, that couple will not have to worry about paying out of pocket for what——

Mr. BRILL. Actually, that is what the article says in the paragraph right below the one you just quoted.

Senator MENENDEZ. Well, first of all, I would appreciate it if you would just let me finish my question first.

Mr. BRILL. Sorry, Senator.

Senator MENENDEZ. So that couple will not have to worry about paying out-of-pocket expenses. In addition to that, there are States like New Jersey that have a law capping hospital charges to 115 percent of the Medicare rates for anyone earning under 500 percent of poverty. So, as a result, less than 5 percent of patients could even be potentially subjected to a chargemaster rate, and those are

people who make enough to afford insurance but often choose not to purchase it.

Here is the question. Considering the vast array of insurance regulations and consumer protections provided and enacted, by both the States and as part of the Affordable Care Act, in addition to the expansion of coverage to millions of Americans who are currently unable to find it, do you not agree that a large part of this problem has been addressed in some very meaningful ways?

Mr. BRILL. No.

Senator MENENDEZ. All right. So, with the facts that I have just finished describing to you, how is that not responsive in part to this challenge?

Mr. BRILL. Well, I am sorry, Senator, but those are not the facts. In New Jersey, for example, many more people fall through the cracks of the regulations limiting the chargemaster charges.

There was a case I looked at at the Passaic Hospital, which is not in the article, of a doctor who was able to bill someone, and then ultimately an insurance company, $9,600 for a half hour's worth of care in the emergency room, and the regulations did not cover that. So I just do not agree with your characterization of what the article says.

Senator MENENDEZ. Well, do you not agree that limiting the low-quality mini-med plans and providing comprehensive coverage is in fact in part dealing with this challenge?

Mr. BRILL. Exactly, which is why I wrote just exactly that in the article. That is what the article says. What I also said is that Obamacare does not address the other fundamental problem, which is the high prices.

The patient who is asked to pay $13,700 for his first transfusion of a cancer drug, he has two problems. The first is, he does not know that that is the price, but the second is, there is nothing he can do about it, because that is the price. Obamacare does zero, nothing, to address that.

As you point out, though, Obamacare would eliminate the kind of insurance policy he had that forces him to pay that. That is a good thing, and the article says that. It does not eliminate the fact that somebody—in this case it is now going to be the taxpayer—is going to pay that $13,700 for a drug that cost the drug company about $200.

Senator MENENDEZ. Well, that is a whole different question. Let me just ask you this, then. So are you suggesting that part of the solution is some form of price control?

Mr. BRILL. That is also in the article. Price control for patented, lifesaving drugs, I think, is necessary, and it is an experiment that has been tried by every other country in the world.

Senator MENENDEZ. Well, let us forget about the drug for the moment. You just described a procedure. Should there be price controls for procedures?

Mr. BRILL. What I described was $13,700 for a drug, Senator.

Senator MENENDEZ. All right. Do you have procedures that you think there should be price controls for?

Mr. BRILL. No. I am not advocating anything.

Senator MENENDEZ. So it is only when you come to medications that you think there should be price controls.

Mr. BRILL. No. I think that, as the article suggests, there should be all kinds of interferences in the marketplace, because it is not a free marketplace. There should be some interference in the marketplace where supposedly nonprofit hospitals are the most profitable businesses in the community, including many in your State. There should be interference with the marketplace where doctors are having lab tests done in labs that they have invested in. There should be interference in that marketplace, yes.

Senator MENENDEZ. Dr. Colella, let me turn to you. Your company shares a laudable goal of increasing transparency and access to health care information. I think that is incredibly important. I agree that empowering people to make better decisions about their health care is the first step in really transforming our health care system.

But I think it is important we provide data that is easily understood and properly used. For example, in your testimony you mentioned the wide variation in the cost of a colonoscopy, for example, even within the same network and within the same region. You correctly say that we have no way of knowing if the higher-cost procedure is the highest-quality one.

However, what we do not know from your testimony are some of the outside factors that could account for the differences in cost. For example, is the highest-cost procedure provided in an emergency room that factors in all the additional costs associated with running a 24-hour/7-day-a-week emergency department, or is the lowest-cost procedure offered in a single physician's practice without those overheads? Which is to say, the total cost of the procedure varies widely, but why is equally as important for us to know so that we can make determinations.

This is the question: with so many different factors going into pricing any given procedure, how can we increase access to data in a way that provides people with usable information?

Dr. COLELLA. Senator, thank you for the question. There are two parts to this. The first one is, our application, our software, allows you to understand where the procedure—in this case the colonoscopy—is done. So you would know if it is done in ambulatory services, in an emergency room, or if it is done in a hospital. Not only that, we even give you outcomes and specific quality measurements on the physician who is doing it. So we empower the consumer already to do that.

For the second part of your question—which is more of a policy one and is absolutely a very fair question, and I appreciate you asking it—how do we account for all the variables in this? Please give us data. You are sitting on a lot of Medicare data. The more data we can get, the more we can actually provide the right quality and cost information to consumers.

Senator MENENDEZ. All right.

Mr. Chairman, I heard earlier that Mr. Brill suggested that we should be scrolling contributions to members. I think that is an interesting idea. I think we should also be scrolling the advertising and/or the contributions to organizations that appear before the committee so we know the perspective of those who are testifying before the committee. I think it would be an interesting proposition.

Thank you, Mr. Chairman.

The CHAIRMAN. I have a couple more questions. Some hospitals I see are pretty fancy. They have fountains, Taj Mahals, and so forth. I just wonder why. You mentioned executive salaries. I do not want to paint all executives with one brush.

Mr. BRILL. No.

The CHAIRMAN. But it is a question. So my question is, at least with respect to DRGs and Medicare, to what degree do they calculate in, or do they not at all, hospital costs for the fountains and all that?

Mr. BRILL. They actually do. They actually calculate all the average overhead for the average hospital, so they do take account of that. I think what we have seen is sort of like what a lot of people say they have seen with higher education: higher prices, higher salaries, more building, an over-supply of courses, an over-supply of beds in the United States, and everybody just keeps getting bigger, and therefore their costs are higher. There really are not the kinds of economies of scale that one would expect, at least that is what I found in my reporting. My colleagues here would know a lot more about that.

The CHAIRMAN. Does Medicare also pay more for fancier hospitals?

Mr. BRILL. No, not in theory. That is not how the DRGs are done.

The CHAIRMAN. Right. So then, is it private payers that make up the difference? Is that basically what happens?

Dr. DELBANCO. Well, I think what is happening is that people do not have the most accurate and objective data on which to make a choice of hospitals, so they look at what it looks like. They look at the ease of parking, they look at patient satisfaction.

All of this matters, but it does not matter as much, when someone gets sick, as whether or not they are going to get the right care that they need. I think if we can balance the more superficial elements with ones that are meaningful to consumers, we will do a better job of right-sizing those kinds of expenditures.

Dr. GINSBURG. Yes. You have some hospitals that have must-have status: insurers need to have them in their networks. Those are the ones that can charge the highest prices and, if they want, build palatial facilities. There are a lot of hospitals that do not have that power, and their facilities are pretty mundane.

Clearly, Medicaid is not a profitable payer for hospitals. It appears to be generally adequate. Hospitals that do not have the ability to generate large margins on privately insured patients are usually able to get to a positive Medicare margin, get their costs down enough so that Medicare is paying its way.

But it is, overall, an issue of, with a third-party payment for health care, with student loans for higher education, they are both very important programs, but in a sense they start removing the consumer from the cost of these things, and one of the results is that costs go up.

The CHAIRMAN. All right. Oh, I am sorry. Chuck came back. I did not see you.

Senator Schumer, you are next.

Senator SCHUMER. Thank you, Mr. Chairman. I thank all the witnesses. I am sorry I could not be here for most of it. I would

just like to first pick up what Dr. Ginsburg said. Well, I want to start with another question. I am a large defender of our great teaching hospitals in New York. Your study, Dr. Ginsburg, said what we have been saying all along.

I go to them, and I say, why are your costs so much higher, and they tell me, because they are higher. Even Dartmouth's study and things like that, they factor out rent and the high cost of living in New York, which is higher, but not that much. What they basically say is, such a large proportion of the people who come there——

The CHAIRMAN. Patients.

Senator SCHUMER. Patients. That is the word I was looking for. I am getting old. [Laughter.] Such a large proportion of our patients have very complicated conditions. We are the place of last resort. When the hospital in Paduca, KY cannot really do it, they say, you had better go here. We take them, and there is all of this. But that is why their costs are much higher. Your studies seem to show that that is the reason, overall, of most of the high costs.

Could you just elaborate on that a little bit? Then I would like to hear what my good friend Steve Brill has to say about that.

Dr. GINSBURG. Yes. Actually, I do not recall having studied teaching hospitals——

Senator SCHUMER. Per se, I know.

Dr. GINSBURG [continuing]. Per se. In a sense, the studies I have done are just looking at price variation.

Senator SCHUMER. Yes.

Dr. GINSBURG. Of course, Medicare, when it created the prospective payment DRG system, actually was so concerned about not paying enough to teaching hospitals—not so much for the teaching function, they paid directly for that, but for the concern that the patients are more complicated and are not going to be picked up by the DRG—that they have what we call the indirect teaching adjustments.

Senator SCHUMER. Yes.

Dr. GINSBURG. MedPAC, over the years, has said that it is too high. The adjustment is too high.

Senator SCHUMER. I do not agree with MedPAC on that issue, as you know. But you are right. Go ahead.

Dr. GINSBURG. So, in a sense, I think we understand that teaching hospitals will cost more, both because of the teaching and because of the differences in patient mix that our DRG system——

Senator SCHUMER. Just does not have. Right.

Steve? Mr. Brill?

Mr. BRILL. Senator, I do not think I know nearly as much as Dr. Ginsburg or the other panelists about how fair as a general matter the DRG is, or how fair it is to teaching hospitals. But I will tell you that, just in looking at the hospitals I looked at, with the bills that I looked at, I do not think the issue was that Medicare was under-paying or cheating these hospitals.

Again, I am just reminded of one of the quotes in the article from Mr. Blum, who, as you know, is a senior CMS official, who said, if you think hospitals lose money on Medicare, just drive down any highway in Florida and look at all the billboards. What are they advertising? It is hospitals advertising for patients. Who are the

patients they are advertising for? It is not teenagers, it is people in Medicare.

Senator SCHUMER. Yes, but that is a different issue.

Mr. BRILL. It is a different issue, yes.

Senator SCHUMER. Hip replacement or something that is standard, you have every leg to stand on—bad metaphor. [Laughter.] You have good grounds in terms of your argument. But when you are dealing with—take Sloane Kettering, a hospital you criticized in your article. So many of their patients have rare, unique, untreatable in other places types of cancers, that the costs are higher, the reimbursement rates do not recognize most of that, and it puts a lot of pressure on them that may come out in unfortunate ways.

But the bottom line is, we need these unique institutions, because they treat patients that other places have tried and failed to treat, or cannot treat. Do you not agree with that?

Mr. BRILL. Yes, I do.

Senator SCHUMER. All right. Good.

Mr. BRILL. With all respect, I take a little bit of issue with the notion that I criticized Sloane Kettering in that piece. I did point out that their survival rate is in fact their business plan. It is even in the bond offerings that they write. What I did say was that whatever their costs are—as you know, cancer reimbursement with Medicare is sort of a special case with special formulas.

But the only thing I did say about Sloane Kettering was that, in one way, it was emblematic of the alternate universe that is health care, where the top fundraiser for Sloane Kettering, to take one example—you shrug it off because it is not a lot of money—but the top fundraiser for Sloane Kettering makes three times as much as the top development officer of Harvard. I just use that as a metaphor for the different world of health care economics. It was not a criticism of Sloane Kettering, which is a marvelous place.

To put it in even more perspective, I hope I made clear, and I will make clear now, that we are not talking about evil people here. We are talking about a marketplace that just does not work, does not make anyone really price-accountable. What happens, whether it is in higher education or medicine or something else, when marketplaces do not work, people tend to maximize their income.

Senator SCHUMER. Yes. And the marketplace—that is the fundamental problem here. I tend to have sympathy for the idea that, because people are not paying themselves, either it is Medicare, Medicaid, or insurance for most people, or they are uninsured and it gets picked up by some other big pool—that the market system does not work in health care.

I—and I am sure some of my colleagues have gone over this—am dubious of the fact that, if you give consumers information, particularly in a complicated area here, there are some who will look at their bill and say, why did I pay $2,000 for somebody I never saw, but most people will not, because they are not paying for it.

That is why, at least in my opinion—I mean, I was for a public option. I was more sympathetic than I usually would be to a single-payer type system, because when you do not—look, who would not give all the money they had to save the life of a loved one? Because of that, we have insurance.

That is the main reason we have insurance. We do not have insurance for cars or houses or anything else where this is the cost and you have to pay it no matter who you are, what you are, and you are willing to put some money aside each year in case, God forbid, something happens to your spouse, your parents, your kids.

Because when you do that, you lose market control. That is why I have always thought free market models do not really work in health care very well. In the Affordable Care Act, we struggled with an alternative. We tried to use markets to create competition among the big insurers, but, at the consumer level, it is very, very hard to get the market to work. You are really rolling a stone uphill.

Any comments on that?

Dr. GINSBURG. Actually, this also goes back to what Senator Rockefeller brought up before. To me, the most important aspect of the public option proposal was not so much to disadvantage insurance companies, it was to apply Medicare pricing power more broadly than just in the Medicare program.

I suspect that that is something we are going to have to come to grips with. We are talking a lot about ways to use benefit design, et cetera, to make markets more competitive. We do not know how successful we will be. In the background, there is always going to be this opportunity of, well, let us just tie it to Medicare payments.

Dr. COLELLA. Yes, Senator Schumer. First of all, I trained in one of the highly specialized hospitals in New York, so I appreciate your comments on the fact that they are some of the best ones in the world. I could not agree more. I think you raise a very valid point. When I practiced medicine, for many years people would come in and pay with somebody else's credit card, so they were completely desensitized from the cost of what they were doing.

The world has changed. In the past 10 years, now we are up to 60 percent of employers in the United States that are offering high-deductible plans. The out-of-pocket payment has grown exponentially in the past 7 years, and the trend is in that direction. So, when you are asking a consumer to pay out of pocket up to $4,000 or $5,000, which for the average American family is real money, it is only fair to provide them with the information necessary to do that. That is how markets can work.

Now, otherwise, we are in the worst of both situations, right, where we do not have an efficient market and we are covering first-dollar coverage. So that is where the big difference is.

Senator SCHUMER. Good point.

Thank you, Mr. Chairman.

The CHAIRMAN. Yes. Let me just somewhat follow up on that. The assumption here is more transparency, more information, somehow will get a better result. Let us take Sloane Kettering. Let us take teaching hospitals. Let us take some hospital, a much smaller hospital, not a teaching hospital, say in my State of Montana. What if all of the information, whatever it all is, were available?

Let us say a teaching hospital, Sloane Kettering. Let us take the teaching hospital. How much is the cost to train residents? How much is the extra cost actually? Go on down the list here, just item

by item by item. So you are in effect the CEO of that hospital, and you know what all the charges are. And the CFO of the big hospital, or somebody, knows what is being charged for whatever it is: the bed, the MRI, the gauze strips, you name it.

My thought is that somebody like Dr. Colella, some entrepreneur, would take that information and would develop some kind of a program, some kind of an app, that would help a little bit, and also would take into consideration a lot of the information that Dr. Delbanco talked about, namely with respect to quality. There are a lot of questions there, obviously. One is, to what degree would that work? The second is, what is proprietary here? What should be proprietary here, frankly?

Mr. BRILL. The analogy may be akin to something I worked on in a prior life, which is legal decisions rendered by the courts. They are not proprietary, they are public. A lot of the CMS data and a lot of the data that hospitals file with the Department of Health and Human Services is somehow licensed to, I think it is the American Hospital Association, in one instance, and the AMA for Current Procedural Terminology billing code data.

They have rules that say that, as Dr. Colella said, if you are a for-profit entity—which I guess, when I was doing this article for *Time* magazine, they mistakenly thought that I was representing a for-profit entity—you are not entitled to it or you have to explain how you are going to use it. It just does not make any sense. I am sure it is rooted in history somewhere.

The CHAIRMAN. Right. Well, I know that is right. That tends to happen around here. But that begs the deeper question: how much of it should be proprietary?

Mr. BRILL. Why not——

The CHAIRMAN. How much of it is, how much of it should be, from the public interest point of view?

Mr. BRILL. As long as it is not patient data, he could tell the large corporations that are hiring him to parse out this pricing information in a hospital, he could tell hospitals who has the most efficient operation when it comes to food service or who has the most efficient operation when it comes to this or that. All that stuff is filed with the government. Some entrepreneur ought to be able to make a lot of money, adding a lot of value in this world, by providing it to people. Why not?

The CHAIRMAN. You are an entrepreneur, Dr. Colella. Why don't you take a crack at it?

Dr. COLELLA. Yes. I could not agree more. I do not know if we are going to make a lot of money. That is not what makes us do this. We are really driven by providing a good service to our customers. I ask you, Senator, think of a world where you walk into a supermarket and you want to buy cereals, and you have a series of boxes there, all different cereals, and you have no price and no information on what cereals you are buying, and then you leave that supermarket and you get a bill 6 months after that, and you cannot read what the bill is. That is completely inefficient. There is complete asymmetry of information, and it is the most opaque industry in the world.

The CHAIRMAN. Well, it is worse than that, because I may not like that brand of cereal, and I don't have to buy it.

Dr. COLELLA. You may not even like what you got.

The CHAIRMAN. When I am in the hospital, I have to take it.

Dr. COLELLA. So that is health care today. If you think about it, this is the most sacred industry that we have. We are not dealing here with bond yields or equity, we are dealing here with madness, death, and birth. We are dealing with the most sacred things that we have. It is really close to immoral, the fact that we cannot even understand what we are buying and what we are paying for it.

The CHAIRMAN. I am going to go back to my question. I am trying to game this out, red flag it. What is the down-side? What is the other side of the coin here? That is why I asked the question about proprietary information, what should or should not be proprietary. Yes?

Dr. DELBANCO. So I think maybe the better analogy is, when you are in the grocery store, each cereal company does not tell you the cost of each of the inputs into making that cereal. Part of what I think the other side of the argument is—you have asked for that—is that I do not think that CFOs actually really know what the cost of each of those inputs is.

There are some line items there, but really what they are operating on is, what is my overall revenue and what are my overall costs, what margin do I want to achieve, and how can I do that by sort of shifting things around? So I think the more we can understand what the costs of those components are and somehow push that to have to be a reality would go a long way.

I do not think we want to stymie innovation by making everybody reveal exactly the cost of their secret sauce if they think they are better at patient through-put, or they think they are better at patient quality, or whatever it is. We do not need to know the granular detail, but they do. I do not think that they are in a situation where they do it this way.

The CHAIRMAN. Well, patents clearly should be protected, trademarks. Certain processes do not have patent protection. I am just trying to figure out, when we push this point in hospitals, et cetera, what reaction might we get that might have some merit?

Mr. BRILL. Just one note that I am not sure anyone has mentioned yet. I think it is particularly important, because we tend to think, with something as important as health care, that the most expensive sort must be the best. I mean, one of the magic aspects of the chargemaster is, if you get a bill for $47,000 and you see that your insurance company got it discounted down to $4,000 and you owe $200, you feel great because you just got $47,000 worth of medical care.

If you were comparing and you saw that the hospital next door would only charge you $8,000, you might say, well, I cannot go to that hospital, because they are not doing a good job. If you knew the costs at both hospitals, then you could see that the $47,000, hypothetically, is not going toward anything having to do with quality, which it is not.

The CHAIRMAN. Does *U.S. News and World Report,* that ranks the 10 best, include quality? I mean, 10 best, 100 best, or something?

Dr. COLELLA. I have been a part of the marketing effort to get on that when I was practicing, and it is a beauty contest about who

does the best belly dance. There really is very little about high quality in that. Unfortunately, I did not do a great belly dance, obviously, but there is absolutely very little link to quality, with scientific measurements, in that report.

The CHAIRMAN. Was it you who said that the most expensive had the least——

Dr. COLELLA. Yes. In Chicago, we have plenty of examples. We have plenty of examples that, because of the asymmetry of information in health care, there is very little correlation between price and quality.

The CHAIRMAN. All right. I have a lot of other questions, but it is about time to wrap up. Thank you. This was very, very helpful. I think you have exposed a lot here. You got a lot of people thinking about this. There is no monopoly on good thinking in this committee, believe me.

But people listening to this hearing will, I think, come up with some good ideas and help us try to find some solutions here. It is an abomination. As you know, we pay about 60 percent more per person for health care in this country than the next most expensive country. There is something not quite right there. I think you put your finger on a lot of it.

I think Senator Schumer is correct when he said market forces have a hard time in this area. Maybe it is all right when you are buying a car, but when you are buying health care it is very, very difficult. Frankly, the Affordable Care Act was an attempt to come up with, in my view, a uniquely American solution.

We did not have any health care system in this country until that act was passed, and even now we really do not. But it is a uniquely American solution, because we are American. We are not Great Britain, we are not France, we are not Germany, we are not Japan, we are not Taiwan; we are who we are.

This committee had to do the best it could, given that we are Americans, we are not French and Swiss and Japanese, et cetera. I think it is a very good act, because it is a good start. It has a lot of warts, a lot of places where things slip through the cracks, but it is a good start, and this hearing is going to help us go forward. Thank you. Thank you very much.

The hearing is adjourned.

[Whereupon, at 12:16 p.m., the hearing was concluded.]

APPENDIX

ADDITIONAL MATERIAL SUBMITTED FOR THE RECORD

Hearing Statement of Senator Max Baucus (D-Mont.)
Regarding Transparency in Health Care Pricing

President Franklin Roosevelt once said that the best way to address a problem is, "In the cold light of day, to analyze it, to ask questions, to call for answers, to use every knowledge, every science we possess, to apply common sense."

Journalist Steven Brill's March 4th TIME Magazine article "The Bitter Pill: Why Medical Bills Are Killing Us" detailed the problem of skyrocketing health care bills in the cold light of day. We're fortunate to have Mr. Brill with us today to analyze the problem, to use knowledge and to apply common sense.

Mr. Brill shares the stories of uninsured and underinsured Americans who survived life-threatening diseases, but whose lives were nearly ruined by medical bills they could not afford.

We learned about Sean Recchi from Ohio. Sean was diagnosed with non-Hodgkin's lymphoma last year at the age of 42. Sean and his wife had just started their own business and were only able to afford a limited health insurance plan, but the hospital did not accept his "discount" insurance. So the hospital made Sean pay nearly $84,000 in advance for a treatment plan and an initial dose of chemotherapy.

Sean was billed off of the hospital's internal list price, known as the "chargemaster." The chargemaster is like the sticker price of a new car. It is inflated, and few would ever pay it. In the case of hospitals, the list price is not just a 5, 10, or 15 percent mark-up; it can be 100 times higher.

But unlike new cars, some people have no choice but to pay the chargemaster price. Who are those people? The uninsured, and the under-insured: People like Sean Recchi.

To start receiving lifesaving care, Sean needed to pay 170 percent of the average American's salary to a hospital – a non-profit hospital. That was just for his first treatment.

Mr. Brill's article shines a light on the little-known chargemaster system used by America's hospitals.

Mr. Brill also tells the story of Rebecca and Scott S., a couple in their 50s living near Dallas. One day last year, Scott was having trouble breathing. Rebecca raced him to the hospital. She thought he was about to die. Scott stayed in the hospital for 32 days until his pneumonia was brought under control.

Rebecca and Scott never imagined that this near death experience would wipeout their life savings. They had exceeded their insurance annual limit and were left with a $313,000 bill.

Thanks to health reform, these stories will soon be a thing of the past. The Affordable Care Act will ensure heartbreaking stories like Scott's and Sean's are no longer the norm.

The law got rid of lifetime limits, and by next year, the law will eliminate annual limits as well.

Families like Rebecca and Scott's will no longer face crippling debt as a result of illness. Insurance companies will be required to cover the medical services people need. And by 2016, the law will also provide coverage to 26 million Americans who were previously uninsured.

The health reform law also prevents hospitals from overbilling uninsured patients using inflated chargemaster prices. The Administration needs to act quickly to finalize the regulations related to this provision.

The Affordable Care Act also helped increase the transparency of what hospitals charge Medicare.

I applaud Medicare for releasing chargemaster data on inpatient and outpatient hospital stays over the last two months. We need to build on this and take a comprehensive look at transparency from the perspective of the consumer.

Some innovative firms like Castlight Health and Change Healthcare are doing just this. They are pioneering analytical tools that can zero in on meaningful pricing information.

These tools can help Americans be smarter consumers. They can help employers and plans form better partnerships with providers that can help keep costs down.

While increased transparency has the potential to change behavior, it will also expose the real thrust of Mr. Brill's article – health care prices are too high in the United States.

Today's hearing will explore the causes of these high prices. Specifically, I hope we can examine the consolidation of hospitals and physicians. The practice can often help produce more integrated care, but consolidation can also lead to higher prices for patients.

I also hope to look at the medical device sector and how it often reaps record high profits, including gross profit margins approaching 75 percent. We need to see if barriers exist that prevent hospitals from more aggressively bargaining for lower prices, and if they do, we need to tear them down.

This hearing is an opportunity to start working through these issues. We know there's a problem. It's been portrayed in the cold light of day by Mr. Brill.

We are here, as President Roosevelt urged, to ask the questions, to analyze the problem. So let us apply common sense. Let us continue to make health care more transparent and affordable. Let us not stop working until we finish the job we started with health reform. I look forward to our witnesses exposing real problems and discussing real solutions.

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Testimony Of Steven Brill
The United States Senate
Committee on Finance
June 18, 2013

Chairman Baucus, Senator Hatch, Members of the Committee:

Thank you for inviting me today to discuss what I found when I decoded and examined seven random medical bills, line by line, for a special issue of TIME Magazine. In the debate over Obamacare and health care reform generally, I had been frustrated that the conversation was mostly about who should pay the high cost of health care – rather than why the cost is so high. My goal, put simply, was to help start that other conversation.

So I decided to follow the money, line by line, to see who's getting all the extra billions we spend in the healthcare marketplace for results that don't justify the cost.

I am happy to summarize what I found – which is that by any definition this is no one's idea of a functioning marketplace.

In a functioning marketplace prices are based on something that is explainable – whether it's the cost of producing the product, the laws of supply and demand, or the quality of the product.

In this marketplace, no one can explain a hospital's charge of $77 for a box of gauze pads, or $18 for a diabetes test strip that can be bought on Amazon for about 50 cents.

No one can explain a supposedly non-profit hospital's $13,702 charge to an underinsured small business owner -- whose family income is about $40,000 -- so that he could get his first dose of a cancer drug that cost the hospital $3,500 and cost the drug company, whose gross profit margins are 90%, a few hundred dollars to make.

No one can explain a $995, four-mile ambulance ride, or an $87,000 bill to a retail worker for a few hours of outpatient care. The bill included $3.00 for the magic marker that marked the spot where a neuro-stimulator

would be inserted into his back. He was then charged $49,000 charge for the neuro-stimulator, which cost the hospital about $19,000. That $19,000 was in turn paid to a company whose gross profit margin is nearly double Apple's, meaning it cost the company about $4,500 to make the product for which the retail worker was billed $49,000.

I should add that this bill, like all the others I examined, was full of acronyms and numerical codes and just plain gibberish that took hours to figure out, line by line. The magic marker, for example, was a line labeled "MARKER SKIN REG TIP RULER," and that was one of the easier items to decode.

In this market, no one can explain why a part time school bus driver was charged – and then successfully sued into paying –$9,400 after she slipped and fell in her backyard and spent a few hours in the Bridgeport Hospital emergency room, where among the charges was $239 for a routine blood-test that Medicare – which pays hospitals based on their actual costs – would pay $13.94 cents for.

No one can explain why the laws of supply and demand or economies of scale don't work – why, if anything, they work inversely. For example, the sale and distribution of expensive diagnostic imaging equipment, such as CT scans, has more than tripled in recent years, but the prices charged for these tests have escalated sharply, with even Medicare – forced to do so by a heavily-lobbied Congress – now paying four times as much for these tests as the German health care system does.

No one can explain anything about what I discovered was a massive internal price list called the chargemaster, which all hospitals have but which vary wildly, hospital by hospital, and have absolutely nothing to do with quality. Nor can anyone explain why the chargemaster's sky-high list prices are charged mostly to those least able to pay, the uninsured or the underinsured.

And no one can explain why the discounts that insurance companies pay to hospitals and other providers off of the chargemaster vary so wildly, which, of course, affect that co-payments and deductibles paid by patients lucky enough to have insurance.

Finally, no one can explain how by far the largest consumer product in our economy – healthcare, which is approaching 20% of our GDP – is so un-consumer friendly that it has spawned a growing cottage industry of patient advocates who read and translate chargemasters for patients and try to negotiate for them.

The reason no one can explain any of this is simple: they don't have to.

They don't have to explain because they have all the information and all the power. Indeed, this is no marketplace at all, if we define a marketplace as involving buyers and sellers who enter into transactions with something approaching a balance of power. For in the healthcare non-marketplace the buyer has no price information and no leverage to do anything it about even if he or she did. The buyer has typically entered that marketplace unwillingly and under great stress. He or she is sick and needs medical care.

That school bus driver didn't wake up one morning and say to herself, "I wonder what they have on sale over at the emergency room today. Maybe I'll go have a look." Instead, when she involuntarily became that hospital's customer, she not only had no price information, she also had no choice. She paid for whatever procedures, lab tests, CT scans and anything else she was told she needed, whether she needed it or not, at whatever price she later found the unintelligible chargemaster had spit out on her bill.

The result of this lopsided sellers' market, I found, is that the world of healthcare economics has become an economy apart from the economy the rest of us live in. While things have been tough for most Americans in the last half-decade, those who run hospitals or sell CT scans or prescription drugs or medical devices have thrived like never before, as if living in an alternate universe. The only exceptions are the nurses and most of the doctors who actually provide health care.

Here's an illustration of that alternate universe. In recent years we've become concerned about the high costs and high salaries associated with higher education. Let's compare higher education to health care. The Bridgeport Hospital, which sued that part time school bus driver, is part of the Yale New Haven Hospital system. The head of Yale New Haven makes $2.5 million – 60% more than the president of Yale University. That's a

phenomenon I found repeatedly across the country where a major university is associated with a hospital, be it Duke, Stanford or the University of Texas.

Here's another telling example: the head of fund raising at New York's Memorial Sloan Kettering Cancer Center makes $1,483,000, while the head fundraiser at Harvard, which raises lots more money, makes $392,000. Lest you think the difference is related to New York's higher living costs, the chief fund-raiser at the Metropolitan Museum of Art in New York makes $345,000.

Indeed, as I wrote in TIME, "In hundreds of small and mid-sized cities across the country – from Stamford, Connecticut to Marlton, New Jersey, to Oklahoma City – the American health care market has transformed tax-exempt 'non-profit' hospitals into the towns' most profitable businesses and largest employers, often presided over by the region's most richly compensated executives."

Oklahoma City is where the ironically named Sisters of Mercy hospital charged that man with the back pain $3 for the magic marker and $49,000 for his neuro-stimilator. Sisters of Mercy Oklahoma City is part of a highly profitable $4.2 billion chain of hospitals that has seven executives earning more than $1 million each and employs a multi-state bill collection firm to bring lawsuits against patients across the Midwest.

The Stamford Connecticut hospital is actually a bigger business than the city of Stamford, itself. It takes in more in patient billings than the city collects in all of its taxes – and even after paying a slew of high salaries to its executives, including $1.86 m to its CEO, it had an operating profit of $63 million – a healthy $12.7% margin. Not bad for a non-profit.

So that's what I saw when I followed the money.

What can or should we do about it? Some changes are obvious.

The first, of course, is transparency. None of this will change until we can see it all, so that those involved can be asked to answer for these profits, these salaries, those $77 gauze pads, those outsized margins on drugs and medical devices and the irrational differences in prices not only among hospitals but among the prices paid by patients and even by insurance companies to the same hospital or diagnostic clinic.

But transparency can only go so far. Take the case of the man who was asked to pay the MD Anderson Cancer Center – in advance – $13,702 for that transfusion, plus $70,000 more for other charges, including the $77 for the gauze pads.

Suppose he knew that the drug cost the hospital only $3,500. Suppose he also knew that the drug cost the drug company just a few hundred dollars to make, and that the drug company had 90% gross profit margins. Suppose he even knew he was about to get soaked for $77 for the gauze pads or $15,000 for various lab tests that Medicare would pay a few hundred dollars for.

So what?

What could he do?

He could literally feel the tumor growing in his chest, his wife told me. He was desperate for his check to clear; in fact, they kept him waiting downstairs, unable to receive his first transfusion, until it did. All the transparency in the world couldn't help him.

Nor, I should add, would the marketplace he was in have been improved, as some suggest, if only he had 'more skin in the game.' He had 100% skin in the game; they made him pay for everything himself, upfront.

Similarly, when I asked the wife of a terminal cancer patient facing more than $900,000 in bills what she thought about getting charged $18 each, or $1,584, for 88 diabetes test strips that could have bought on Amazon for about 50 cents each, she responded much as Mrs. Lincoln might have had she been asked whether she liked the play. "Are you kidding?" she said. "I'm dealing with a husband who had just been told he has Stage IV cancer. That's all I can focus on . . ." She had, she said, just stuffed all of the bills into a box and didn't look at them until after her husband had died.

So, we need more than transparency.

In that regard I should remind you of the math I did about a patient in Stamford with chest pains that turned out to be indigestion, but whose bill

for a few hours in the emergency room was $21,000. She was, it turns out, 64 years and 11 months old. Had she been allowed to buy coverage from the one buyer in the marketplace with real information and market power – Medicare – she not only would have saved thousands of dollars but the taxpayers would have saved, too. Having her in Medicare at age 64 would cost the taxpayers a lot less than the Obamacare plan to subsidize what will be her much more expensive private insurance premiums.

But giving everyone the chance to enroll in Medicare, thereby establishing it as the single payer, does not seem politically realistic, despite the math and despite what I found to be Medicare's highly efficient performance compared to that of private insurance companies – performance that is mostly operated, I found, by private sector contractors.

So what else can we do short of that? We have to do something because in a marketplace where buying is not voluntary, someone has to step in to regulate the sellers.

We could consider requiring hospitals and everyone else to charge the same transparent prices to everyone. We could consider price controls on prescription drugs and medical devices, or limits on profits made by non-profit hospitals.

We could touch the third rail of Democratic politics by implementing sensible malpractice tort reform that will limit the number of unnecessary tests done on patients.

And we could consider anti-trust enforcement against hospital systems that are increasingly consolidating with other hospitals and even buying up doctors' practices and clinics to secure a lock on medical services, thereby forcing insurance companies to pay whatever these providers demand so that the insurer can have the hospital chain in its network.

In short, transparency is important because it starts the conversation we have to have and didn't have in the debate over Obamacare – which is what can we do about outlandish healthcare prices. I'm proud of the role that I played in starting that conversation. But it's only a start. Once we follow the money, we have to act to stem the flow.

Thank you again for inviting me.

Testimony of Giovanni Colella, MD, CEO and Co-Founder of Castlight Health, Inc.

United States Senate Committee on Finance
Hearing: "High Prices, Low Transparency: The Bitter Pill of Health Care Costs"
18 June 2013

Chairman Baucus, Ranking Member Hatch, and distinguished members of the Committee. It is my honor to have this opportunity to testify before you today.

I came to this country 29 years ago to complete my medical training. What started as a medical career became a business career as I found my passion creating start-ups to improve the quality and efficiency of health care delivery in the United States. While I now spend my time as an entrepreneur in the business world and not as a doctor in the examination room, my goal remains the same: to try to improve the health and well-being of my fellow Americans.

It is this commitment, combined with the enormous need that brings us here today, that led me to co-found – with Bryan Roberts and Todd Park-- Castlight Health five years ago.

Our goal at Castlight is to help millions of Americans make better decisions about their health care. We provide cost and quality information that helps people lower their health care spending while improving the quality of their care. From health care claims data, we can determine the price paid for a service – by geography and by doctor – which we combine with an individual's benefit plan information to provide the actual out-of-pocket cost that person will pay for a medical service. We then combine this accurate pricing information with quality information and patient reviews, and present it to the employees of our clients through easy-to-use web and mobile applications. Because patients rarely have been provided with this kind of information, we provide rich educational information that explains what the prices mean, how to interpret quality information, and how to use the other convenience information to get the most out of their health care benefits. This enables patients to make better and more informed decisions about their health care, and reduce the amount that they and their employers spend on health care. We have helped customers achieve engagement rates of up to 80 percent, which is an astounding accomplishment. And this has translated into millions of dollars in savings for our customers.

Today, I want to review with you the state of health care price and quality transparency; why it is important economically and medically to make these data available; the impact these data have on consumers' health care decisions, financial circumstances, and health outcomes; and what the federal government can do to bring more transparency to the health care market.

THE STATE OF HEALTH CARE PRICE AND QUALITY TRANSPARENCY

I first became aware -- and admittedly obsessed -- with the issue of health care transparency a few years ago when my mother, old and very ill, needed care. I wanted to bring her to the United States because we have the best health care in the world. I was fortunate that I could get my mother excellent care, and as a doctor and a businessman, I wanted the facts about the highest-quality care for her and what it would cost. However, as hard as I tried, I could not get that

information. I could not determine if a name-brand, world-renowned medical center was indeed the best, or whether it was worth the price. And if it was not, where I could find that care and what would it cost.

This puzzled me. When you go shopping for a car, you know its price: it's right there on the window, and there are numerous sources for information about key aspects of quality. When you are booking a hotel room, likewise, it's easy to know the charges and to instantly access evaluations on everything from the cleanliness of the bathroom to the friendliness of the front-desk staff. Yet, when it comes to our health care system, it has been virtually impossible for a consumer to find out what it will cost for any given procedure or course of treatment, and to determine whether the quality of care is worth the price.

This makes no sense from either a market or medical perspective. Without transparency in health care, consumers ultimately end up paying more and getting worse care, and we as a country end up spending more on health care than is necessary.

This is not a new problem, but it's one that is growing in significance as the US works to decrease the rate of health care cost growth, and as households find themselves paying more out of pocket for their own health care costs—which currently is about 5 percent of total household spending, as shown in Figure 1.

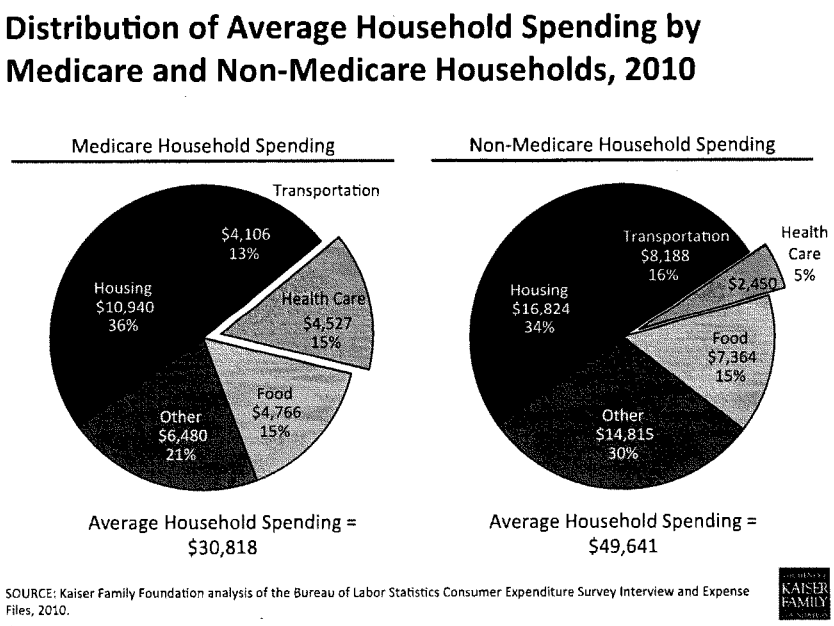

Figure 1

As a result of escalating health care costs, employers have begun to shift costs to employees. For instance, 58 percent of all employers now offer high-deductible health plans.[1] Average deductibles for patients on cost-sharing plans continue to rise and are currently over $1200.[2]

Because of this trend, the 60 percent of consumers with employer-sponsored insurance increasingly have a real financial incentive to manage health care spending and seek out quality. Similarly, American businesses have an imperative to keep their health care costs down and the quality of the care their workers receive up. Unfortunately, over the past decade, health care premium increases have consumed all real-wage growth in America.[3] If companies can keep health care costs down and quality up, they can be more competitive, hire more workers, and share their savings with workers through increases in wages and other benefits. Finally, our entire country has an interest in seeing a more competitive health care sector in which market forces drive value up, reduce the rate of health care cost growth, and lessen the burden of health care spending on state and federal budgets.

To be clear, spending less on health care does not mean receiving lower quality care. As a matter of fact, the opposite is sometimes true. We know from years of study that there is huge variation in price and quality across our country, across individual states, across individual cities, and even across doctors practicing in the same hospitals. And unfortunately, prices and quality have almost no correlation. Thus, facilities and providers with the highest costs for medical services may provide low quality care, and, conversely, high-quality facilities and providers may charge the lowest fees for care.

To illustrate the lack of correlation between price and quality, in Figure 2, we have combined Castlight data for the price of pregnancy in Chicago mapped against Leapfrog's pregnancy-related quality measures. The results are startling. The highest charges come from hospitals with the worst quality ratings. And the lowest charges come from hospitals with the best quality. The difference in prices is $11,721, or over 300 percent. Similar findings for other episodes of care have been reported by those analyzing Medicare claims data and, most famously, by the work of Jack Wennberg and the team that produces the Dartmouth Atlas of Health Care.

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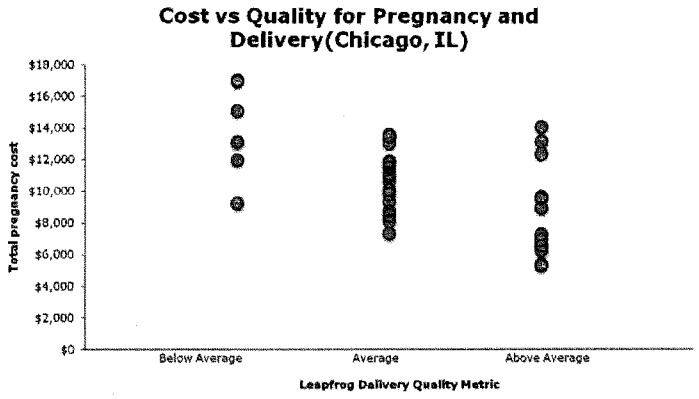
[1] "Aon Hewitt Employer Survey," July 17, 2012, http://aon.mediaroom.com/index.php?s=25776&item=132919.
[2] "Mercer Employer Survey," November 17, 2013, http://www.mercer.com/press-releases/1400235.
[3] Executive Office of the President. *The Burden of Health Insurance Premium Increases on American Families*. Available at: http://www.whitehouse.gov/assets/documents/Health_Insurance_Premium_Report.pdf.

Figure 2 [4]



THE IMPACT OF A LACK OF HEALTH CARE TRANSPARENCY

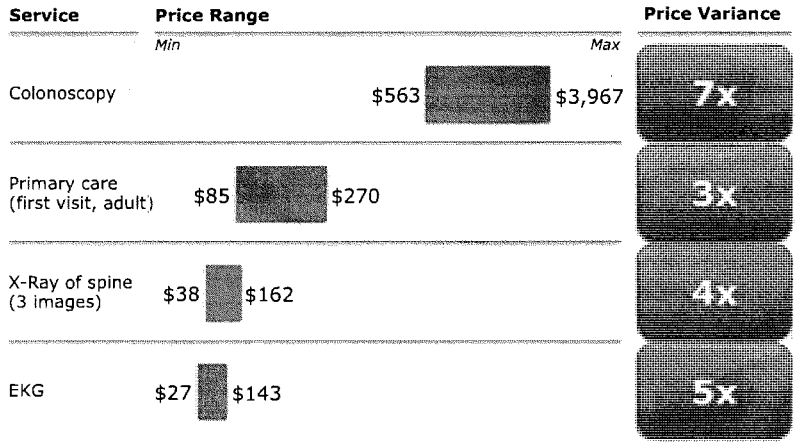
At Castlight, we use a variety of data sources, including actual insurance claims data to determine prices. Additionally, to help our users assess relative quality and value, we combine Medicare's quality data set with more than 30 of the best available, peer-reviewed, public and private quality measures. Thus far, we have found similar discrepancies between price and quality across all conditions and in all of our markets. This means that there is ample opportunity for patients to save money and get better care once this data becomes transparent.

As shown in Figure 3, many routine procedures show an alarmingly large variance in price even within an employer's network. Take for example a colonoscopy — a test commonly used to screen for colorectal cancer. Castlight found that prices for colonoscopies, for the same health plan in the same geography can vary sevenfold. This equates to a difference of approximately $3,500 between the lowest cost and highest cost provider for the same test. Is the colonoscopy that is $3,500 more expensive a better colonoscopy? There are no data that suggest that it is. As a result, without price and quality transparency, consumers are blindly choosing providers when lower-cost providers with commensurate or higher quality very often exist.

[4] Data provided by Castlight Health and Leapfrog (2013).

Figure 3 [5]

Cost variation by service – single health plan in one geography



A $3,500 difference in the cost of a colonoscopy is significant for any consumer. If a worker is in the deductible phase of their health plan, they could pay the entire difference. If they have consumed their deductible, most Americans pay between 20 and 40 percent of the price of their care up to their out-of-pocket maximums. Therefore, this difference equates to at least $600 and as much as $3,500 of unnecessary spending. For a worker making $30,000 a year, that $600 bill can be more than just a tough expense to swallow; it could mean the difference between getting by or not.

This lack of transparency in the health care marketplace does not only affect consumers getting individual services. It also skews how health care is delivered in the US overall. This is particularly true when care is provided out-of-compliance with evidence-based medical standards. More than $600 billion is wasted every year in avoidable costs due to unneeded care, preventable complications or errors, or the right care not being delivered.[6]

Consider, for example, the overuse of medically unnecessary tests and procedures. The fee-for-service health care reimbursement system in the US provides incentives for health care providers to deliver care based on volume, not outcomes. For instance, evidence suggests that most back pain is resolved with rest, physical therapy or other conservative treatment and does not require MRI's or other advanced testing or treatments.[7] Yet among low back pain patients in the US,

[5] Data provided by Castlight Health (2013).

[6] Diana Farrell, Eric Jensen, Bob Kocher, MD, Nick Lovegrove, Fareed Melhem, Lenny Mendonca, and Beth Parish, "Accounting for the cost of US health care: A new look at why Americans spend more," McKinsey Global Institute (2008). Available at: http://www.mckinsey.com/insights/health_systems/accounting_for_the_cost_of_us_health_care.

[7] Pham HH, Landon BE, Reschovsky JD, Wu B, and Schrag D, "High-Value, Cost-Conscious Health Care:

nearly a third of MRI's are for patients who had not first tried other potentially effective treatments.[8] Such unnecessary MRI's create significant financial costs. In California alone, Castlight found that the median price of an MRI among the privately insured is $746 (and the cost in this region varied from $458 to $3,409).

Health care providers, health plans and lawmakers in the US are making significant efforts to address many of these systemic issues. For example, Medicare will no longer pay for certain avoidable hospital complications. However, payers without policy-making power, such as employers, face continued increases in overall health care spending and bear high costs of poor quality and non-evidence-based care. This has a significant impact on the cost of American products, and the ability of US companies to compete. Visibility into pricing and quality is critical to curbing costs, and by offering these together in an integrated transparency solution, true behavior change is possible.

We have found that consumers actually will utilize transparency; they will "shop" for elective medical care and change their choices when exposed to data on price and quality. This is consistent with research funded by the Agency for Healthcare Research and Quality that consistently has found that when you present people with meaningful price and quality data, they will make better choices for their health care.[9] In fact, most health care in America is non-urgent, enabling patients to comparison shop; therefore, data transparency could substantially improve competitiveness for most health care services.

For instance, a recent survey of employees in companies and organizations that offer Castlight found that more than half of respondents use Castlight's data to make health care decisions. Ninety one percent of employees want their employers to continue offering Castlight, and of those who have used it, 94 percent plan to do so again. And when that same study looked at how people use Castlight, it found that 65 percent use it to search for doctors or view their choices for care; 60 percent look to see how much they have spent on health care; and 51 percent use it to review past claims to see how much they spent. These data show that Castlight is now acting as a trusted advisor and guide for people to interact with the health care system.

And this activity is having a real economic impact. One national grocery retailer who started using Castlight saw a 44 percent increase in the number of "high-spender" employees making proactive choices about health providers – and 66 percent of those employees selected services that cost less than the reference price. This led to a 9 percent reduction in projected health care spending for that business. Another Castlight customer reported that 61 percent of their employees used quality and price data from Castlight to influence their health care decisions over a six-month period. This contributed to a staggering 13 percent reduction in health care spending as compared to the expected trend by that company, which allowed them to reinvest in other benefits programs for their employees.

Concepts for Clinicians to Evaluate the Benefits, Harms, and Costs of Medical Interventions," *Annals of Internal Medicine* 154 (2011):181-189.

[8] Pham HH et al.,"Rapidity and modality of imaging for acute low back pain in elderly patients," *Archives of Internal Medicine* 169 (2009):972-81.

[9] Judith H. Hibbard, Jessica Greene, Shoshanna Sofaer, Kirsten Firminger and Judith Hirsh, "An Experiment Shows That A Well-Designed Report On Costs And Quality Can Help Consumers Choose High-Value Health Care," *Health Affairs* 31 (2012): 560-568. doi:10.1377/hlthaff.2011.1168.

The implications of the Castlight experience are clear: when given data on price and quality in an accessible format, employees use it to make smarter health care decisions, and both the employees and employers save money.

POLICY PRESCRIPTIONS

With these benefits in mind, I believe that we need to do more to bring transparency and competition to health care so that the health care system can deliver better value to consumers. As Drs. Ezekiel Emanuel and Robert Kocher, a member of our board of directors, recently wrote, we need to embrace a "transparency imperative: All data on price, utilization, and quality of health care should be made available to the public unless there is a compelling reason not to do so."[10] To accomplish this, we believe there are steps that Congress, along with the Executive Branch, can take to significantly improve transparency and the health care market.

First, we should enshrine the "transparency imperative" into law by requiring all payers to make claims data publically available, with privacy protections, for utilization and quality measurement. Only 12 states currently maintain all payer claims databases, with varying degrees of accessibility. [11] Public access to these data will go a long way in advancing consumers' ability to select high quality care and providers. For example, robust claims data yields one of the key predictors of quality: physician case volume, a measure that is currently extremely difficult for consumers to access.

Second, the Department of Health and Human Services (HHS) should build on the momentum of its recent release of data for 130 in-patient and out-patient procedures to make much more of its data available to the public.[12] The immediate response to the release of these data reflects the thirst for, and power of, transparency. Yet there is pricing data for more than 1,000 additional procedures that were not released. Moreover, it is critical that Medicare make physician quality data widely accessible. The legislated release of this data has already been delayed six months.

Third, the federal government should relax data restrictions on access to Medicare data without compromising safeguards to protect privacy. Provisions to release Medicare data to "qualified entities" already exist.[13] However, the definition of "qualified entity" limits access to this exceptionally useful data to non-profit entities that must make all of their analyses available publicly for free. These stringent requirements effectively block new entrants and for-profits from utilizing this powerful dataset to develop innovative and disruptive solutions to improve transparency.

Fourth, purchasers of health care should have unfettered access to their claims data to enable price and quality transparency initiatives. These purchasers are often employers, from whom

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[10] "Robert P. Kocher and Ezekiel J. Emanuel, "The Transparency Imperative," *The Annals of Internal Medicine* (2013), doi: 10.7326/0003-4819-159-4-201308200-00666.

[11] "Interactive State Report Map," APCD Council, NAHDO, UNH, http://www.apcdcouncil.org/state/map.

[12] "Medicare Provider Charge Data," *Centers for Medicare & Medicaid Services*, last modified June 2, 2013, http://www.cms.gov/Research-Statistics-Data-and-Systems/Statistics-Trends-and-Reports/Medicare-Provider-Charge-Data/.

[13] "Centers for Medicare & Medicaid Services," Federal Register Volume 76, Number 235, December 7, 2011, http://www.gpo.gov/fdsys/pkg/FR-2011-12-07/html/2011-31232.htm.

most non-elderly Americans receive their health insurance.[14] Employer purchasers are eager to adopt market driven solutions that help their employees stem the rising cost of care and should be able to fully access the critical data required to do so.

Finally, pro-transparency measures, such as those in Massachusetts, should be passed by other states, or by the Congress, to prevent providers from restricting access to pricing data.[15] In response to significant, unwarranted price variation, Massachusetts passed legislation in 2012 that promotes price transparency and prohibits health plans and providers from entering into contracts that prevent disclosure of the providers' prices from consumers.[16] Such contracts prevent consumers from making informed decisions and solely benefit the interests of the market-dominant providers that are able to negotiate such terms. Some argue that without such contracts lower-cost providers will raise their rates, thereby increasing the average cost of care. We have, in fact, seen the opposite where pricing transparency has brought market forces to health care and where providers have reduced the cost of care.[17]

The health care system in the US is changing rapidly. The adoption of promising new reimbursement and delivery models, such as accountable care organizations (ACO's), has created many exciting opportunities to improve the quality and more effectively manage the costs of health care.

However, a key element that is missing is transparency. Today, it is a challenge for consumers to factor price and quality considerations into their decision-making processes about health care, which results in higher costs and lower quality for them, higher health care expenses and reduced productivity for their employers, and an unsustainable health care cost growth rate for the country. By taking these small, but meaningful steps toward more transparency, you will go a long way to bringing market discipline and better value to the American people.

Thank you for the opportunity to speak with you today.

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[14] "Employer-Sponsored Coverage," *America's Health Insurance Plans*, http://www.ahip.org/Issues/Employer-Sponsored-Coverage.aspx.

[15] "Session Laws: Chapter 224 of the Acts of 2012," *The 188th General Court of the Commonwealth of Massachusetts*, https://malegislature.gov/Laws/SessionLaws/Acts/2012/Chapter224.

[16] "AG Coakley Releases Second Report Examining Key Drivers of Rising Health Care Costs," Office of the Attorney General of Massachusetts, June 22, 2012, http://www.mass.gov/ago/news-and-updates/press-releases/2011/ag-releases-2011-report-on-health-care-costs.html.

[17] Wall, J.K., "Hospitals proving themselves wrong about prices," *The Dose blog*, June 6, 2013, http://www.ibj.com/the-dose-2013-06-06-hospitals-proving-their-own-arguments-wrong-about-prices/PARAMS/post/41776.

TESTIMONY

The Importance of Price Transparency from the Employer and Consumer Perspective

June 18, 2013

Statement of:

Suzanne F. Delbanco, Ph.D.
Executive Director
Catalyst for Payment Reform

Before the Committee on Finance
U.S. Senate

Chairman Baucus, Ranking Member Hatch, distinguished Committee members. I am Suzanne Delbanco, executive director of Catalyst for Payment Reform (CPR). Thanks for the opportunity to be here with you to discuss the importance of transparency in health care pricing as a means to achieving a higher quality and more affordable health care system.

Background

Catalyst for Payment Reform (CPR) is an independent, non-profit organization working on behalf of large employers and public health care purchasers to catalyze improvements in how we pay for health services and to promote higher-value care in the U.S. Currently, CPR has 30 members, mostly large private employers, such as 3M, Dow Chemical Company and Safeway, as well as eight state agencies such CalPERS—California's Public Employee Retiree System-- and the Medicaid agencies from Arizona, Ohio, South Carolina, and Tennessee.

CPR's long term goal is to spur changes in how we pay for health care so that our members and the rest of the nation can get better value for every health care dollar. By value, we mean the best combination of quality and costs. But there are other building blocks that must also be in place to drive our health care system to produce better and more affordable care. CPR designated price transparency as one of its special initiatives because we cannot imagine a high-value health care system without it.

What Has Led to the Call for Price Transparency Today?

Employers and other health care purchasers, as well as individual consumers, continue to face rising health care expenditures. Employers' health care costs continue to rise -- a March 2013 report indicates average employer costs are expected to increase 5.1% in 2013.[i] As a result of these growing costs, and in an effort to stem them, employers are asking those for whom they provide health care

benefits to take on a greater share of the cost. Whereas consumers have not been a significant force in the past, employers are now designing and implementing employee benefits, such as high-deductible, consumer-driven health plans, to motivate consumers to seek more efficient, higher-quality care. In fact, deductibles more than doubled between 2003 and 2011,[ii] and 34% of employer-sponsored plans now have deductibles of $1,000 or more.[iii] Consumer-directed health plans are now the fastest growing type of health plan, with 19% of covered workers currently enrolled in them.[iv] This is expected to grow in response to the requirements of the Affordable Care Act.

Total out-of-pocket spending by consumers is now at an estimated $312 billion annually.[v] But while many consumers now have a more vested interest in expending health care resources carefully due to new benefit designs, health care costs are also becoming unaffordable for a growing number of Americans. The rate of increase of average family premiums has exceeded the consumer price index and is chiefly responsible for the stagnation of family incomes.[vi] Premiums now account for 20% or more of the average American family's income.[vii]

Purchasers believe that pressure from consumers for higher-quality, more affordable care, is a powerful, underused lever. Once consumers are positioned to shop actively for medical services due to increased financial responsibility, it is important to make information about those medical services transparent to facilitate their decision-making. For a consumer strategy to succeed, it is critical to expose the variation in prices for services – the prices for standardized services such as colonoscopy can vary as much as 1000%.[viii] It is also critical to provide consumers with meaningful quality information to help them identify high-value providers, especially because price is rarely indicative of quality.

There is much greater awareness of unwarranted payment variation now than in the past. In 2010, CPR commissioned Paul Ginsburg of the Center for Studying Health System Change to examine variation in commercial payment amounts across and within eight markets. Three large private health insurers

provided data which illustrated, for example, that in San Francisco the average inpatient hospital payment rates were 210% of Medicare whereas in Los Angeles, the average inpatient stay at the 25th percentile cost 84% of Medicare, at the 75th percentile cost 184% of Medicare, and the highest paid hospital received 418% of Medicare. Ginsburg concluded that payment variation seems to be tied to provider market power, which is likely to create even greater disparities as consolidation continues and put more providers in a position of being able to refuse requests for price transparency.

What is Price Transparency?

CPR uses the U.S. Government Accountability Office's (GAO) definition of price transparency, which is "the availability of provider-specific information on the price for a specific health care service or set of services to consumers and other interested parties." GAO defines price as "an estimate of a consumer's complete health care cost on a health care service or set of services that (1) reflects negotiated discounts; (2) is inclusive of all costs to the consumer associated with a service or services, including hospital, physician and lab fees; and, (3) identifies the consumer's out-of-pocket costs (such as co-pays, co-insurance and deductibles)."[ix]

How Could Price Transparency Help Employers and Consumers?

Transparency on health care prices increases the likelihood that consumers will choose health care providers that deliver effective and cost-efficient care.[x] Price transparency can also be an important tool for health care providers. Recent studies suggest that price transparency can help providers evaluate and identify the most appropriate and affordable care for their patients.[xi] Furthermore, employers and health plans cannot implement some of the more promising benefit and network designs without it.

Reference and value pricing are examples of such approaches. Reference pricing establishes a standard price for a drug, procedure, service or bundle of services, and generally requires that health plan members pay any allowed charges beyond this amount. Value pricing is when quality is also taken into consideration in addition to the standard price.

Two of CPR's members, CalPERS, and Safeway, Inc. have led the way in experimenting with using reference pricing to signal to providers that their unwarranted price variation is no longer acceptable and to engage consumers in making more value-oriented selections of providers. Price transparency is at the core of these programs, enabling consumers to minimize their financial exposure. For example, CalPERS set a reference price for hip or knee replacement at $30,000. CalPERS enrollees are responsible for coinsurance of 10% of the allowed charge, which is capped at $30,000. If a patient receives care from a facility that charges more, that patient would pay 10% coinsurance on $30,000 and the full difference between the allowed charge and the $30,000 reference price. CalPERS has said that it saved $16 million in the first year of the program.[xii]

What Efforts Exist to Advance Price Transparency Today?

The main activity in the private sector comes in the form of transparency tools that have been developed by health plans and independent commercial vendors. There is solid competition in this space and these tools vary in functionality and availability, though they have been rapidly improving in recent years and even months.

While the health care industry could, on a voluntary basis, provide highly-effective price transparency to health care consumers, there may be instances in which government must step in to ensure that citizens have access to sufficient price information to support the selection of high-value providers. The federal government has made some strides in the area of transparency in health care. On the price front, the

Center for Medicare and Medicaid Services (CMS) provides an online tool that provides beneficiaries with expected out-of-pocket drug costs, and just recently released hospital charge information. On the quality front, CMS also operates Hospital Compare, Physician Compare and Nursing Home Compare which all post provider performance on a variety of quality metrics.

At the state level, 34 states currently require reporting of hospital charges or reimbursement rates. Some states operate consumer-facing transparency tools such as "New Hampshire Health Cost" and in Massachusetts, "My Health Options." In the Report Card on State Price Transparency Laws, CPR worked with the Health Care Incentives Improvement Institute to examine existing states laws on price transparency to determine whether states were stepping in to provide consumers with price information. Forty-three states have laws that address price transparency in health care in some manner. The Report Card graded state laws on four dimensions: 1) on what breadth of services they require price information be available; 2) on what breadth of providers they require price information be available; 3) whether the law required provider charge information versus the actual negotiated payment amount; and, 4) how accessible the price information was to consumers. Just two states, New Hampshire and Massachusetts, earned 'A' grades according to criteria in these four dimensions, while 29 received an F due to the absence of any laws or laws that met few of the criteria.

What are the Challenges to Achieving Effective Price Transparency?

In the commercial sector, it is very difficult for health plans, employers or other vendors to produce transparency on prices for all health care providers. There are some health care providers, particularly those with market power, who put into their contracts with health plans a prohibition on revealing to health care purchasers or consumers any information about payment amounts. While health plans are working independently and through legislation to phase out such contract provisions, and they are relatively rare, in some markets where dominant providers succeed in achieving these terms, there can

be gaping holes in the information consumers need to make informed decisions about where to seek care. As a result, while price transparency could be an effective element of introducing greater competition and innovation in the health care delivery system, market power may allow those providers with higher-than competitive prices to keep their high-prices obscured.

Another barrier to employers and consumers having the most effective price transparency is the position of some health plans that information contained in health insurance reimbursement claims data, particularly the payment amounts, is proprietary. They take this position even in the case of customers for whom they provide administrative services only and do not take on the insurance risk (e.g. a self-insured employer). As a result, some health plans will not permit self-insured customers to give their own claims data to a third-party vendor, such as Castlight Health, to populate a consumer price transparency tool.

Making transparency in health care work for consumers can be challenging. Without both price and quality transparency, consumers may get the wrong message – consumers could mistakenly correlate higher prices with higher quality, which is often not true in health care.[xiii] In addition, our current reliance on fee-for-service payment, with individual codes for every test, procedure and visit, may make it hard for lay consumers to estimate their total costs for an entire episode of care since they make not know what the components of their care will be.

Price transparency alone is unlikely to change consumer behavior. Pairing it with some sort of incentive to use it and to act on it is more likely to engage consumers. New benefit designs can make price and quality information meaningful, such as the reference pricing example above.

Furthermore, it is unknown how providers will react to greater price transparency, particularly if transparency is implemented in such as way as to enable them to gain access to each other's negotiated

payment amounts. It is possible that less expensive providers may try to raise their rates to those of their higher-priced competitors. It is also possible that providers with prices higher than the average would bring their prices down out of fear of losing patient volume. This is an area that needs further research.

How is CPR Working to Meet the Needs of Employers, other Health Care Purchasers, and Consumers?

In our work to support employers and others who purchase health care for consumers, CPR has created a variety of tools to help them advance price transparency in health care.

Most employers and other health care purchasers rely on health plans to act as their agents in the health care marketplace, administering benefits and contracting with health care providers on their behalf. As a result, CPR has developed a series of tools as well as venues in which purchasers can push health plans to meet their need for price transparency.

In order to alert health plans about the priority purchasers place on price and quality transparency, we have created standard questions that purchasers can pose to them when they are determining which health plans with whom they would like to contract. We have also created model health plan contract language purchasers can use as a starting point for contract negotiations with the plans. This model language outlines the purchaser's expectations of the contracted health plan regarding price and quality transparency. We support both of these sourcing and contracting approaches with CPR-moderated user groups that occur quarterly between each of the four largest national health plans and their employer-purchaser customers. At each meeting, we ask the health plans to report their progress on their own price transparency tools, whether they meet CPR's specifications for these tools (more detail below), whether they allow self-insured customers to give their own claims data, including the payment component, to a third-party vendor for analysis or for use in a transparency tool, and what percent of

their professional claims and hospital claims run through health care provider contracts that limit sharing price and quality information with consumers.

In response to the various frustrations many employers and other health care purchasers have experienced in seeking the cooperation of health plans and health care providers to make health care prices transparent, CPR issued its Statement on Price Transparency to request that health plans and health care providers remove these barriers by January 1, 2014. This statement was also endorsed by many other business groups as well as the AFL-CIO and AARP.

In its first National Scorecard on Payment Reform, released on March 26, 2013 and designed to track the nation's progress on payment and other related reforms, CPR found that 98% of health plans say they have cost calculator tools of some kind. However, they also reported that only 2% of patient members ever use them. We will track this finding over time as we release subsequent annual Scorecards.

While there is a proliferation of consumer transparency tools, not all of them are easy to use or provide meaningful information. After reviewing the leading consumer transparency tools about 18 months ago, when CPR found many helpful features spread across the various tools but not all contained in any one tool, CPR decided to create Comprehensive Specifications for the Evaluation of Consumer Transparency Tools as of way of pointing to the features we think tools must contain to be effective. Most tools, whether designed and operated by health plans or independent vendors are getting better rapidly. However, one of the biggest shortcomings is the separation of price and quality information, which can make it very difficult for the consumer-user to identify which provider or procedure options offer the best overall value.

How Could the Federal Government Advance Price Transparency?

The various stakeholders in the health care industry that are privy to price information could work together to provide effective price transparency. But since a voluntary effort is unlikely to lead to complete transparency, there is a role for government. The federal government could facilitate price transparency in a variety of ways.

First, building on its recent release of hospital charge data, it could share charge, payment, and quality information for a much broader range of providers and services.

Second, in the federal government's efforts to provide transparency tools for consumers, such as www.hospitalcompare.gov, it could work to incorporate the features designated as most important in CPR's Comprehensive Specifications for the Evaluation of Consumer Transparency Tools. The federal government also has a unique role to play in meeting the price transparency needs of those receiving health benefits from the federal government as well as the uninsured.

Third, the federal government could, through the federally-facilitated exchanges, insist on price transparency from qualified health plans. CPR's model health plan contract language includes price transparency requirements that could be used by exchanges in their contracting with these plans.

Lastly, in order to help employers and other self-insured customers of health plans meet their fiduciary obligations in the delivery of health benefits, the federal government could ensure they have access to their own claims data, including the payment component, for use in consumer transparency tools, including those operated by third-party vendors.

There is also a role for state government to play. States can implement laws that require health care prices (not just charges) in the commercial sector for a broad range of health care services and providers

to be easily accessible to consumers. The State Report Card on Price Transparency Laws outlines the criteria that it takes to be an 'A' state in this regard. States can also create All Payer Claims Databases designed to produce robust quality and price information for use by consumers.

Conclusion

Large employers and other health care purchasers cannot envision a high-value health care system in which there is not meaningful and usable price and quality transparency. Catalyst for Payment Reform commends the Senate Finance Committee for delving into this issue. CPR will continue to work to ensure that employers and consumers can be armed with the information they need to help evolve our health care system to one in which we understand and feel confident about the value we are getting for each health care dollar we spend.

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CATALYST FOR PAYMENT REFORM

Price Transparency

An Essential Building Block for a High-Value, Sustainable Health Care System

Action Brief

INTRODUCTION

As health care costs continue to rise, purchasers remain focused on strategies that can help to bring costs under control. These pressures have facilitated a movement by many purchasers to engage consumers – their employees and their dependents – more fully in their health care decisions, including taking on a greater share of their health care costs. In their efforts to manage costs, health care purchasers, including large employers and states, recognize consumers need information on both health care price (particularly a consumer's expected out-of-pocket contribution) and quality (especially outcomes measures and other measures of safety, effectiveness, timeliness, efficiency, and equity),[1] along with the right incentives to seek higher-value care. In recent years, information about quality has become more transparent; however, meaningful price information is still difficult to obtain.[2] Purchasers, plans, and providers need to do more to advance price transparency and to marry price and quality data together to help consumers assess their treatment options.

What is price transparency? Why should purchasers push to make price and quality information public? What are some of the existing tools and strategies in the current marketplace and their limitations? This Action Brief examines these questions and provides purchasers with concrete ways they can foster transparency, which in turn can help catalyze much needed reform in our health care system.

WHAT IS PRICE TRANSPARENCY?

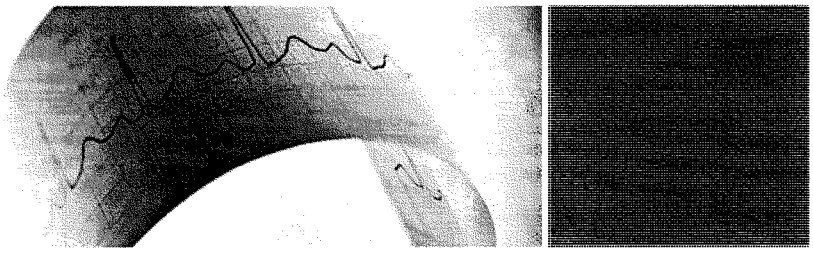
Depending on who you talk to in health care, "price transparency" can have many different definitions. For the purposes of this Action Brief, Catalyst for Payment Reform (CPR) defines price transparency as "the availability of provider-specific information on the price for a specific health care service or set of services to consumers and other interested parties."[3]

Price is defined as "an estimate of a consumer's complete health care cost on a health care service or set of services that 1) reflects any negotiated discounts; 2) is inclusive of all costs to the consumer associated with a service or services, including hospital, physician and lab fees; and, 3) identifies the consumer's out-of-pocket costs (such as co-pays, co-insurance and deductibles)."[4]

The price a consumer pays for a particular service depends on a number of variables

PRICE EXAMPLE: An insurer has negotiated a rate of $1,000 with a particular in-network provider for a chest MRI, and therefore, the cost is $1,000. A consumer has $200 remaining to meet his/her deductible and the coinsurance is $160; the individual is responsible for $360 and the insurer pays $640. In this case the consumer's "price" for the MRI is $360. Price transparency exists when, for example, prior to seeking care, a consumer knows his price will be $360 for that particular provider and can compare the price for chest MRIs with other providers.

It is also important for consumers to understand the total payment for the service, including what the plan (or purchaser) pays and the remaining price they owe for that service. This broader context is important as we inform consumers about the total cost and price of specific health care services as they make decisions and seek care in the health care system.



Some of the most promising payment reform approaches such as reference and value pricing cannot be implemented effectively without price transparency.

including whether that consumer is insured or uninsured and whether the provider who performs the service is "in-network" or "out-of-network." For uninsured consumers, the price for a service is always the same as the total payment a provider receives. For insured consumers who have not yet met their deductible or are visiting an out-of-network provider when their health plan has no out-of-network benefit, the price of care is also the same as the total payment to the provider. However, for insured consumers visiting an in-network provider, the price of care will often represent only part of the payment for that care; the insurance plan will pay the rest. Regardless of the arrangement, the "price" as understood herein is the amount of payment for which the consumer is responsible. Despite one's insurance status, however, it is important to note that maximizing the consumer benefits of price transparency will require attention to medical literacy issues, including the fact that it can be very challenging for most health care consumers to understand medical terms as well as how health care payment works, including their own insurance benefits and billing.

WHY SHOULD PURCHASERS SUPPORT TRANSPARENCY?

Purchasers and consumers need transparency for three primary reasons: (1) to help purchasers contain health care costs; (2) to inform consumers' health care decisions as they assume greater financial responsibility; and, (3) to reduce unknown and unwarranted price variation in the system.

PURCHASER COST SAVINGS Based on a 2012 report, health care costs rose only 5.4% in 2011 because of benefit plan redesign and increases in employee contributions. Without changes to plan design and increases in employee contributions, "average cost trends would have been 8% in 2011 and anticipated to be only slightly lower (7.4%) next year."[5] Another recent report indicates that large employers expect health care costs to rise by 7% in 2013.[6] While this stabilization in trend may be a testament to the impact of current efforts, health care costs are still growing at about twice the rate of the general Consumer Price Index; in fact, health care cost trends have outpaced wage growth for more than a decade.[7]

To address these trends further, many purchasers are implementing a variety of cost containment strategies, including care management of high-cost patients, reference pricing, centers of excellence for high-cost, complex services, and other strategies including wellness incentives and more extensive coverage of preventive care. Purchasers aiming to manage health care costs by implementing these payment reforms and benefit design changes will find price transparency essential to their strategies. Some of the most promising approaches such as reference and value pricing cannot be implemented effectively without price transparency.[8]

SUPPORTING CONSUMERS AS THEY ASSUME GREATER FINANCIAL RESPONSIBILITY As health care costs continue to rise, most purchasers are asking their consumers to take on a greater share of their costs, including both health insurance premiums and out-of-pocket expenses. According to the Kaiser Family Foundation, consumers pay 47% more for coverage than in 2005 while wages have only increased by 18%.[9] Furthermore, 34% of employer-sponsored plans have a deductible of $1,000 or more for single coverage, more than three times the average in 2006. Enrollment in consumer-driven health plans (CDHP), such as health savings accounts (HSAs), has risen to 19% of all employer-sponsored plans, making them the second most popular plan type after traditional PPOs.[10] According to an American Association of Preferred Provider Organizations (AAPPO)-commissioned analysis of the Mercer National Survey of Employer-Sponsored Health Plans, 61% of *large* employers and 48% of *all* employers expect to offer CDHPs five years from now. These trends, coupled with overall increases in health care expenditures, mean consumers now spend $312 billion out-of-pocket annually.[11] Even with the Patient Protection and Affordable Care Act's (PPACA) pending guidelines on the maximum deductible and out-of-pocket expenditures for family coverage at $4,000 and $11,900 respectively, these trends will still continue.[12]

Despite taking on a greater share of their health care costs, consumers cannot be prudent health care shoppers without information on quality and price. Consumers research quality and prices regularly for a variety of goods and services, from cars and washing machines to mechanics and restaurants. Research[13] – and common sense – indicates they need and want easy-to-understand, quality *and* price information about their care. Consumers seeking non-urgent care would benefit the most from access to price and quality information because they have time to examine data and make decisions about predictable services, unlike in emergency situations.[14] And consumers have proven that when they have price and quality information, they in fact make strong decisions based on value. Research shows that when they have access to well-designed reports on price and quality, 80% of consumers will select the highest-value health care provider.[15]

REDUCING UNWARRANTED VARIATION Several health care researchers have examined the topic of price variation and found that significant price variation exists for hospitals and physician services across markets and even within markets. Without transparency, those who use and pay for care may be unaware of the range in potential costs and what little relationship price has to quality. In extreme cases, some hospitals command almost 500% of what Medicare pays for hospital inpatient services, and more than 700% of what Medicare pays for hospital outpatient care.[16] Variation in payment to providers can be as much as ten-to-one for services like colonoscopy and arthroscopy

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The implementation of a transparency tool with consumer adoption and behavior change can provide cost reductions for purchasers. For example, a purchaser with a median health care cost trend and 20,000 consumers could expect to save $6.7 million of health care spending over three years. This projection is based on consumer adoption rates of 10% in the first year to 50% by the third year.[17] Coupling transparency with related benefit strategies has proven even more effective. CalPERS instituted limited price transparency and reference pricing with high-quality medical centers for hip and knee replacements and estimated $16 million in savings in 2010.[18]

Without price transparency, it is difficult for anyone to understand the extent of price variation, its causes, or the ability of purchasers to address the problem.

in a single geographic area.[19] Studies on price variation suggest that it is largely due to provider market power resulting from "must have" status in a network, unique service offerings, and/or size.[20] The recent trend in provider consolidation has given some provider systems even greater market power relative to their peers.[21] Recent reports from the Health Care Cost Institute show a 4.6 percent increase in private spending over 2010-2011, due almost wholly to higher prices, not utilization or the intensity of services.[19] Without price transparency, it is difficult for anyone to understand the extent of price variation, its causes, or the ability of purchasers to address the problem.

WHAT ARE SOME OF THE EXISTING EFFORTS ON PRICE TRANSPARENCY?

Health plans, with their extensive data on claims, contractual reimbursement, credentialing and quality information, may be best positioned to disclose price and quality information today. Some health plans are trying to offer members access to shopping and transparency tools; however, many of these tools are currently limited in their scope and in the specificity of provider prices. This is partly due to pressure from the providers with whom they negotiate, operational challenges with respect to the data, and limitations of existing consumer portals. The additional presence in the market of other independent vendors developing similar tools is also likely spurring the creation of better tools at a faster rate. States and the federal government may also take steps to move price transparency forward in a comprehensive and meaningful way.

KEY ELEMENTS OF COMPREHENSIVE TRANSPARENCY TOOLS FOR CONSUMERS

CPR has developed a comprehensive set of specifications to help purchasers evaluate existing health care transparency tools. Such tools must provide access to broad information about providers and the services they offer. The best tools will present information intuitively so consumers can easily use it to decide where to go for care. Ideally, information would be on a single integrated platform of web and mobile applications and paired with trained support personnel such as nurses, coaches, or other customer representatives.

CPR developed these specifications after reviewing the capabilities of existing tools and with consideration of criteria developed by other organizations. The specifications fall into five categories:

1. **Scope** – the comprehensiveness of provider, including in-network and out-of-network providers, and service information, including price, quality, and consumer ratings.
2. **Utility** – the capability of the tool to facilitate consumer decision making through features that permit comparisons of health care providers' prices, quality, and care settings.
3. **Accuracy** – the extent to which consumers can rely on the provider, service, and benefit information.
4. **Consumer Experience** – the user-friendly nature of the tool, including the availability of mobile applications and easy-to-find, easy-to-understand information.
5. **Data Exchange, Reporting and Evaluation** – the extent to which claims data are exchanged with purchasers according to all privacy laws, the ability of purchasers to use the data with third-party vendors, regular reporting to the purchaser, ongoing improvement of the tool, and the ability of users to rate the tool.

HEALTH PLAN TOOLS AND PURCHASER DATA National health plans are heeding the call from purchasers to share price and quality information with consumers and are developing transparency tools for their patient members to help them access and understand these data. Some plans have had tools for several years, while others just months. Even in the most sophisticated tools, precise price transparency is still relatively rare. CPR's review of the current cost calculators or estimators offered by some of the largest health plans[23] found they provide varying levels of price transparency for select services. The Pacific Business Group on Health also recently performed a "secret shopper" study of the tools developed by major health plans.[24] The results demonstrate wide variation in their functionality and cost comparison capabilities. Examples of differences include variation in the number of services for which price information is available and the ability to compare prices across care settings. In response, some purchasers are turning to third-party vendors – separate from their health plans – to create tools for their consumers. However, this requires health plans to release purchasers' data to a third-party vendor, which many health plans have not yet agreed to do.

OTHER VENDORS' ACTIVITIES Like health plans' tools, other vendors' tools vary in functionality and in the scope of information they offer. Many tools focus solely on price, or estimates of price. Others exclusively present quality and patient-submitted reviews. Some tools even alert consumers about opportunities to lower their out-of-pocket costs and can be customized to individual benefit designs. Only a few comprehensively provide information on quality, price, patient experience, network providers, and benefit design.

These transparency tools also have their limitations. Other vendors typically do not have access to real-time data for their tools as health plans do. They may also have to obtain medical, pharmaceutical, behavioral and other clinical claims data from multiple sources to populate the tool. Despite these limitations, other vendors' tools play a valuable role, particularly when health plan tools do not meet the needs of purchasers and consumers. Their presence in the market enhances competition and spurs innovation to make more robust, user-friendly tools available.

STATE ACTIVITY Currently, 34 states require reporting of hospital charges or reimbursement rates[25] and more than 30 states are pursuing legislation to enhance price transparency in health care.[26] The structure and requirements of the laws and pending legislation vary widely by state and some only include pilot programs and pre-implementation steps. While most states have some disclosure requirements in place, these statutes generally do not cover the actual prices specific providers charge for performing specific treatments.[27]

Currently, 34 states require reporting of hospital charges or reimbursement rates and more than 30 states are pursuing legislation to enhance price transparency in health care.

When well-designed databases collect the right information, they can transform data into valuable price and quality information.

In recent years, several states, such as Massachusetts, Maryland, and Utah, have also established databases that collect health insurance claims from health care payers into statewide repositories. Known as "all-payer claims databases" (APCD) or "all-payer, all-claims databases," they are designed to inform policymakers and other stakeholders about various state-based cost containment and quality improvement efforts. According to the APCD Council, nine states operate mandatory APCDs,[28] three states are currently implementing mandatory APCDs,[29] and two states have voluntary APCDs.[30, 31] State laws can direct an APCD on what information it collects and reports. When well-designed databases collect the right information, they can transform data into valuable price and quality information.

California has a new voluntary, multi-payer claims database managed by the Pacific Business Group on Health. The new platform, a nonprofit entity called the California Healthcare Performance Information System (CHPI), will pool claims and other data from California health plans and CMS. CHPI is applying to be deemed a Medicare Qualified Entity so that it can include Medicare claims data (on California's Medicare beneficiaries). CHPI will produce physician, group and hospital performance ratings using quality, efficiency, and appropriateness measures.

States have taken additional steps to ensure that claims information is not restricted under contractual stipulations such as "gag clauses." California recently signed into law SB1196 which states, "No health insurance contract in existence or issued, amended, or renewed on or after January 1, 2013, between a health insurer and a provider or a supplier shall prohibit, condition, or in any way restrict the disclosure of claims data related to health care services provided to a policyholder or insured of the insurer or beneficiaries of any self-insured health coverage arrangement administered by the insurer."[32] In practice, the law will allow plans to share data with Medicare Qualified Entities.

Some states have developed their own price transparency tools for consumers. Both New Hampshire and Maine have posted health care costs on state-sponsored websites called New Hampshire Health Cost and Maine HealthCost respectively. Using these

A 2010 Commonwealth Fund report states that "APCDs are proving to be powerful tools for all stakeholders in states where they are being used, filling in long-standing gaps in health care information. They include data on diagnoses, procedures, care locations, providers, and provider payments, and offer both baseline and trend data that will guide policymakers and others through the transitions that health care reform will bring in years to come. As with all data sets, there are limitations to APCD data, but capturing information from most if not all of the insured encounters in a state can still create a powerful information source." The report also indicates the challenges APCDs face, despite some positive results. "While APCDs have undeniably proven to be valuable where they are in use, their development and implementation require states to resolve the numerous political and technical challenges associated with large-scale information systems. Such challenges include engaging and educating all major stakeholders, determining governance and funding, identifying data sources, and determining how the data will be managed, stored, and accessed."

sites, both insured and uninsured individuals can compare the prices of various medical services for different providers. Similarly, Minnesota state officials unveiled a new tool for insured consumers to gain access to *average* negotiated rate information on the website, Minnesota Health Scores.

FEDERAL ACTIVITY The federal government can also play a role in transparency. One of the best examples of price transparency in a federal program is the disclosure of drug prices in the Medicare Part D program, signed into law in 2003. For most individuals, the Part D benefit is structured so that an individual pays 100% of the cost of a drug when he or she is in the "donut hole" (after exceeding the initial prescription coverage and before reaching an annual maximum for out-of-pocket costs). Medicare provides an online tool where an individual beneficiary can enter the name and dosage of the drug and a database will provide the beneficiaries with their expected out-of-pocket costs.

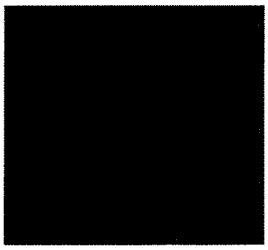
Medicare also offers a Hospital Compare website, which allows Medicare beneficiaries to compare the quality of hospitals in their area. The website provides a "snapshot" of hospital quality and includes six aspects of care: timely and effective care; readmissions, complications and death; use of medical imaging; survey of patients' experiences; number of Medicare patients; and Medicare payment. By making this information available on the federally-managed Hospital Compare platform, the federal government has taken a step in the right direction. However, to make the site truly valuable for patients, Medicare needs also to share price data. Finally, the Patient Protection and Affordable Care Act (PPACA) of 2010 includes a provision that requires hospitals to provide charge information to the public annually.[33]

WHAT ARE THE CHALLENGES TO ACHIEVING PRICE TRANSPARENCY?

While our health care system has made significant strides in publicly reporting data on provider performance and quality, purchasers, plans, providers, other vendors, and policy makers need to do more to help price information flow freely, both overall and for specific services. A number of obstacles to achieving this goal exist, including the complexity of the health care marketplace itself. Our health care system has enormous variation in care delivery, different approaches for measuring outcomes, and wide-ranging products and services. The diversity of payers in a market that contract with providers at different rates and serve different populations (e.g. Medicare, Medicaid, individual, group) compounds the complexity. As purchasers, providers and policymakers pursue change, lack of provider competition, health plan restrictions on data use, and policymakers' concern about the "unintended consequences" of price transparency also pose challenges.

LACK OF PROVIDER COMPETITION Lack of provider competition in a market, particularly among hospitals and specialists, makes it easy for some providers to refuse to reveal prices to consumers. The major health plans have attempted to address this by removing so-called "gag clauses" from their contracts or by working with facilities outside of the normal contracting cycle to seek permission to share their price information in transparency tools. Much effort has been made to remove such contractual barriers to transparency, but there are still gaps in the information accessible to consumers, particularly in markets like California. Legislation, such as the California example above, can address this issue – essentially preventing providers from entering into contracts that don't allow plans to share data with plan members or a Medicare Qualified Entity.

HEALTH PLAN RESTRICTIONS ON DATA USE Due to restrictions from health plans, many self-funded purchasers face challenges with using their own claims data to build transparency tools for their consumers. These purchasers receive information and data



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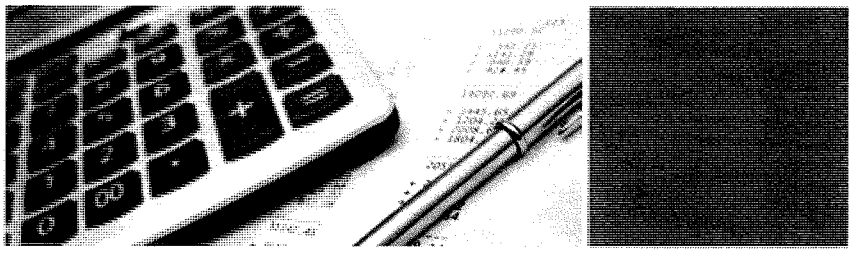


Purchasers believe that more competition between those developing and offering transparency tools will promote innovation and better serve the needs of consumers in the long run.

from contracted health plans and their data vendors, but still may wish to contract with other parties to build price transparency tools for their consumers. However, some health plans do not allow purchasers to give information to other vendors about the prices the plan paid to providers for the purpose of price transparency, arguing that price information is proprietary and confidential, even though it was the purchaser's funds that paid these claims. With third-party vendors increasing the options in the market, more purchasers are raising the issue of "who owns the data" in private and public dialogues.

This controversy may be less about the law, and more about health plans' interests. Self-funded purchasers, insurers, and third-party data vendors must all adhere to applicable privacy laws and regulations, including HIPAA, ERISA and HITECH. The transfer of data between such parties is protected under these laws and regulations. Health plans, in their effort to be responsive to market demands for greater transparency, are developing more sophisticated and proprietary transparency tools using the claims data. Their investment in these tools is significant and they have concerns that providing claims data to other vendors will introduce or support competing products.

Unfortunately, with this restriction on the data, purchasers and consumers may be losing out. Purchasers who conclude that a plan's tool is not robust or consumer-friendly or meeting their needs in some other way, may want to pursue other options. Purchasers largely believe data about their funds paid to providers belongs to them and that they have the right to provide it to whoever can perform the services they need. Furthermore, purchasers believe that, in the long run, more competition among those developing and offering transparency tools will promote innovation and better serve the needs of consumers.

UNINTENDED CONSEQUENCES OF PRICE TRANSPARENCY While price transparency can help purchasers design value-based benefits and address unwarranted price variation, there are well-founded concerns about the potential unintended, negative consequences of price transparency. For instance, price transparency without quality information could perpetuate consumers' misconception that prices correlate with quality, with some consumers thinking higher-priced care is better. Furthermore, while standard economic theory suggests that price transparency leads to lower and less varied prices, price transparency also has the potential to generate higher prices and anti-competitive provider behavior.

For example, Hospital A could analyze Hospital B's prices across town and decide to negotiate for increases if Hospital B seems able to charge more without sacrificing

volume. Similarly, physicians and hospitals could use price information collectively to set the level of discounts to negotiate with health plans. Further, if all prices are public, it could dilute a health plan's ability to negotiate favorable volume discounts. This could result in higher health care costs for purchasers and consumers, at least in the short term. And finally, price transparency could cause confusion among the general public, at least initially, as individuals' out-of-pocket costs vary with their insurance status, source of coverage (private, public, uninsured), and benefit design. One market-based solution to mitigate this potential unintended consequence is to make sure that consumers have access only to their own relevant pricing information based on their health plan and specific benefit design.

Policymakers can also take steps to remedy these problems. Policymakers can and should use existing laws to monitor marketplace behavior, as they do in other industries, to ensure that providers do not use price data in an anti-competitive manner.

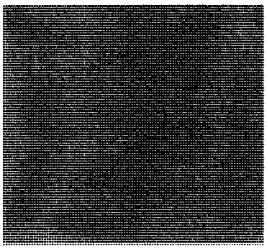
When plans limit access to the claims, price, or reimbursement data necessary to populate robust consumer shopping tools, they disadvantage purchasers and consumers. To minimize or avoid unintended consequences, sharing data to develop transparency tools must be done carefully and constructively. The more health plans and other vendors there are offering tools to meet the demand from large employers and purchasers, the more competition there will be to produce better tools. When plans control the data for competitive or proprietary reasons, they restrict the strategies and tools purchasers can use to control health care costs and enable consumers to maximize their benefits and engage in informed decision-making. As providers, health plans and purchasers make more information on price and quality accessible, consumers will become more educated about value, learning that more expensive care isn't always best.

Policymakers can and should use existing laws to monitor marketplace behavior, as they do in other industries, to ensure that providers do not use price data in an anti-competitive manner.

ACTIONS PURCHASERS CAN TAKE TO DRIVE TRANSPARENCY

Purchasers can and should play a central role in ensuring consumers and their families have access to comprehensive, easy-to-use tools that provide understandable information about health care quality and price. Purchasers can:

1. Require their contracted health plans to:
   - Provide easy-to-understand price and quality comparison tools to consumers. (CPR's Health Plan Request for Information, Model Health Plan Contract Language, and Specifications can support and guide this conversation);
   - Help educate consumers about the benefits of using such tools and their functionality; and,
   - Allow purchasers to share their claims data with third-party vendors for building a transparency tool for consumers or for help with claims data analysis and interpretation.
2. Educate their consumers about how price transparency tools can help them make important decisions about their health care and how to use them:
   - Use the PBGH cost-calculator "Tip Sheet" to identify tactics to encourage consumers to register for and use their plan's cost calculator tools;
   - Build on price transparency tools with innovative benefit designs and payment reform programs, such as reference pricing and packaged-pricing for specific services like maternity care that will make the price information highly relevant; and,
   - Encourage consumers to ask their physicians and other providers for an estimate of what they will charge before receiving care.



3. Be vocal about the need for effective price transparency:
   - Endorse CPR's "Statement on Transparency" and stand behind it in the sourcing, contracting and management of health plans and other vendors (sign on here);
   - Support health plans and other vendors who are developing these tools by sending the message to providers that transparency is important to you and your consumers – their patients; and,
   - Use CPR's Specifications for transparency tools in the development of a new tool or in the evaluation and comparison of existing tools.
4. Take part in statewide data collection efforts:
   - Statewide data collection efforts can improve access to credible quality and cost information. A fact sheet prepared by the All-Payer Claims Database Council provides background information. Their website also lists state efforts: http://apcdcouncil.org/;
   - California purchasers can visit www.pbgh.org/CHPI to learn more about the California Healthcare Performance Information System, the new multi-payer claims database in California; and,
   - If gag clauses or other contractual provisions between health plans and providers create barriers to the release of quality and price information in your area, support efforts – voluntary or legislative – to make that information transparent. Write a letter to the involved parties (e.g. hospital CEOs) indicating that you and your consumers want them to make this information available.

ABOUT US

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CONCLUSION

Purchasers believe making quality and price information transparent to consumers is a powerful building block for supporting them in making more value-oriented choices, which can improve quality and reduce costs for everyone. Yet barriers to price transparency remain, including pushback from providers and limitations on data-sharing by the health plans. Purchasers will continue to encourage health plans to develop robust, consumer-friendly transparency tools and to share data with other vendors so they can do the same. CPR's health plan RFI questions and model contract language can help purchasers to push plans on transparency and related payment reform strategies. Purchasers can also engage in advocacy and regional efforts to collect data, such as all-payer claims databases. Finally, purchasers can use CPR's specifications to compare existing transparency tools and select one that meets their needs. Using these tools, purchasers can foster transparency, driving the health care marketplace closer to meeting the needs of those who use and pay for care.

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CATALYST FOR PAYMENT REFORM

Comprehensive Specifications for the Evaluation of Transparency Tools

INTRODUCTION

As health care costs continue to rise, consumers, including employees, their families and dependents, are taking on a growing share of their health care costs. Seeking to implement strategies to help them manage those costs, health care purchasers, including large employers and states, recognize they need to provide consumers with information on both prices and quality along with incentives to seek high-value care. While the health care system has made information about quality more transparent in recent years, much more work needs to be done to advance price transparency and to connect price (particularly consumers' expected out-of-pocket contribution) and quality (especially outcomes measures and other measures of safety, effectiveness, timeliness, efficiency, equity and patient centeredness) data to capture overall value. Health plans and other vendors are developing transparency tools to meet some or all of these needs.

To help purchasers evaluate and compare available tools, CPR developed specifications for optimal transparency tools. These specifications include price, quality, provider information, consumer engagement, treatment-decision support and other features. CPR understands that these tools will evolve over time based on consumer needs and demands and that current tools are unlikely to include all specifications. However, the specifications will support purchasers working with health plans and other vendors to develop tools that meet their needs and those of consumers. We hope they will also spur developers of transparency tools to broaden the scope of providers, services, and markets these tools address.

CPR developed these specifications after reviewing the capabilities of existing tools and with consideration of criteria developed by other organizations (see last page for acknowledgements). The specifications fall into five categories:

- Scope – the comprehensiveness of providers, including in-network and out-of-network providers, and service information, including price, quality, and consumer ratings.
- Utility – the capability of the tool to facilitate consumer decision making through features that permit comparisons of health care providers' prices, quality, and care settings.
- Accuracy – the extent to which consumers can rely on the provider, service, and benefit information.
- Consumer Experience – the user-friendly nature of the tool, including the availability of mobile applications and easy-to-find, easy-to-understand information.
- Data Exchange, Reporting and Evaluation – the extent to which claims data are exchanged with purchasers according to all privacy laws, the ability of purchasers to use the data with third-party vendors, regular reporting to the purchaser, ongoing improvement of the tool, and the ability of users to rate the tool.

ABOUT US

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INSTRUCTIONS

As purchasers address consumers' need for transparent price and quality data, they will be faced with comparing tools with various options and features; some of these are more important than others. At a minimum, CPR recommends purchasers use its "Core Transparency Tool Specifications" to compare and evaluate tools. For a more comprehensive, thorough evaluation of a transparency tool's full capabilities, CPR recommends using the "Expanded Transparency Tool Specifications."

Purchasers can print this document to assist with assessing or comparing the capabilities of various transparency tools offered by health plans or other vendors.

TRANSPARENCY TOOL SPECIFICATIONS

SCOPE

CORE SPECIFICATIONS			EXPANDED SPECIFICATIONS	
YES	NO		YES	NO
☐	☐	Comprehensive provider coverage At a minimum, the tool should include information on all network physicians and hospitals. Ideally, the tool would also include information on out-of-network physicians and hospitals.	☐	☐ **Consumer financial liability** Displays consumer financial liability based on remaining deductible, copay, and out-of-pocket maximum to show likely price of care at the moment of query.
☐	☐	Comprehensive service coverage Includes all medications, services, and procedures (inpatient, outpatient, diagnostic, office visits, etc.).	☐	☐ **Integrated savings and account balances** Savings and account balances are integrated across health savings accounts (HSA, HRA, FSA) so patients know amount of funds available to pay for services.
☐	☐	Meaningful provider information Includes provider performance (e.g. physician recognition awards, quality indicators for the individual physician or his/her affiliated medical group, patient experience), contact information (e.g. phone, address, email, access hours), whether or not accepting new patients, credentials (e.g. board certifications, education, relevant specialty information), Maintenance of Certification, languages spoken, and network status (in-network, out-of-network).	☐	☐ **Consumer engagement tools** Additional features available to engage consumers, such as real-time messaging, email exchange between provider/plan and consumer, savings calculators, highlighting of high quality providers, etc.
☐	☐	Meaningful service information Includes, at a minimum, relevant information on quality (including outcomes measures and other measures of safety, effectiveness, timeliness, efficiency, and equity), price (including out-of-pocket contribution and total price), and patient experience to support consumers seeking value-oriented care.	☐	☐ **Addresses health literacy** Includes lay terms when describing services, as well as detailed medical explanations.

If ***YES***, the core specifications *are* met, consider evaluating the expanded specifications.

If *NO*, the core specifications *are not* met, talk to your vendor or consider other tool options.

UTILITY

CORE SPECIFICATIONS			EXPANDED SPECIFICATIONS	
YES	NO		YES	NO
☐	☐	Interface Users can obtain price, quality, provider, and personalized information (e.g. account balances, benefit design, etc.) through an intuitive, easy-to-navigate interface.	☐	☐ **Flexible search capability** Allows various search capabilities (e.g. by procedure category, specialty, centers of excellence, accountable care organization, PCMH, location, price, quality, provider name, and in-network vs. out-of-network).
		If *YES*, the core specifications *are* met, consider evaluating the expanded specifications.	☐	☐ **Compares alternative health care settings** Allows for comparison of alternative care settings (e.g. ER vs. urgent care vs. retail clinic).
			☐	☐ **Emphasis on high-value providers** Clearly identifies higher-value providers using easy-to-understand and easy-to-identify words or symbols. The methodology behind the value distinction should be made available to the consumer.
			☐	☐ **Consumers can see how well they shop** Provides consumers with real-time, annual, personalized scorecards about their own health activities, including use of high-quality/efficient providers, price of services, in- and out-of-network use, use of services, and overall financial impact of choices compared to benchmarks where possible.
		If *NO*, the core specifications *are not* met, talk to your vendor or consider other tool options.	☐	☐ **Consumers have access to clinical support** Users have access to live telephonic and online patient education and decision support (e.g. diabetes information, treatment options, etc.), financial guidance (e.g. how to use the benefit efficiently), reference pricing, and other programs (e.g. centers of excellence, tiered networks) from people trained to explain health and benefits.
			☐	☐ **Appointment scheduling** Provides assistance with online appointment scheduling and personalized calendars that display and alert user of upcoming appointments and the need for preventive screenings.
			☐	☐ **GPS capability** Provides users with maps and directions to provider offices.
			☐	☐ **Information security** Fully compliant with all data and information security methods (HIPAA compliant at a minimum).

UTILITY			
CORE SPECIFICATIONS			EXPANDED SPECIFICATIONS
YES	NO		YES NO
☐	☐	Presentation of information Presents information in a format that facilitates informed decision-making by consumers, including the ability to compare providers' prices, quality, and care settings.	☐ ☐ **Provider rating** Allows users to rate and review providers and publishes their ratings and reviews to make them easily accessible to all users of the tool.
		If *YES*, the core specifications *are* met, consider evaluating the expanded specifications.	☐ ☐ **Mail-order medications** Allows users to fill or refill prescriptions online to be delivered by mail.
			☐ ☐ **Procedure labels** Procedures are displayed simultaneously by both common name and procedure code, including ICD-9 & ICD-10 when available.
			☐ ☐ **Customized user profiles** Allows consumers to save user-specific information, such as demographic information, benefit design, status of deductibles, coinsurance, account balances (HRA, HSA), copayments, location, provider preferences (e.g. name, gender, experience), treatment preferences, EHR, historical usage, benefit design, status of deductibles, and user-generated notes.
		If *NO*, the core specifications *are not* met, talk to your vendor or consider other tool options.	☐ ☐ **Includes physician-hospital relations** Displays physician and hospital relationships where physicians have privileges for applicable specialties and diagnoses/procedures.
			☐ ☐ **Integration with Patient Medical Record (PMR)** Allows for and automates the transfer of provider cost and quality information to the PMR.

ACCURACY

CORE SPECIFICATIONS

YES NO

☐ ☐ Timely and up-to-date
Service (e.g. price and quality) and provider (e.g. location and contact) information is accurate and updated regularly to ensure accuracy.

☐ ☐ Price information
Price information reflects the total out-of-pocket expense (including remaining deductible, copay, and out-of-pocket maximum reached) for a specific service at the moment of query, based on the individual consumer's benefit plan and provider-specific contracts (both negotiated in-network and expected out-of-network). The price should reflect the actual price and not the average price for a region.

☐ ☐ Quality information
Quality information is based on direct outcome measures when available, and otherwise is based on nationally-endorsed, consensus-based process or structural measures. Performance measurement should follow the criteria outlined in the *Patient Charter for Physician Performance Measurement, Reporting and Tiering Programs* (the *Patient Charter*) found at http://healthcare-disclosure.org/docs/files/PatientCharter.pdf.

If ***YES***, the core specifications *are* met, consider evaluating the expanded specifications.

If ***NO***, the core specifications *are not* met, talk to your vendor or consider other tool options.

EXPANDED SPECIFICATIONS

YES NO

Price sources
If contracted rates are not used, price information should be based on the following:

☐ ☐ 1. Historical prices: Physicians For physicians (groups and individuals), price information based on actual unit price derived from historical claims.

☐ ☐ 2. Historical prices: Hospitals For hospitals (systems and individual), price information based on actual unit price derived from historical claims.

☐ ☐ 3. Historical prices: Pharmacy For pharmacy services price information based on actual unit price.

☐ ☐ **Bundled services**
For complex services (e.g. knee replacement), price, displayed as a single price estimate, reflects all services expected to be included.

☐ ☐ **Consumer-specific estimates**
Price estimates reflect users' health status and the complexity of the level of services when possible.

☐ ☐ **Quality information is actionable/reliable**
Quality data is provider-specific and is only displayed when a sample size yields a confidence level of 90% or greater.

☐ ☐ **Process measures of quality**
When no outcomes data are available, quality information is based on nationally-endorsed, consensus-based process measures, or measures proven to lead to improved clinical outcomes (e.g. CMS quality metrics, Leapfrog quality indicators and other measures developed in alignment with the *Patient Charter for Physician Performance Measurement, Reporting and Tiering Programs).*

☐ ☐ **Accurate and timely consumer information**
All consumer-specific personalized information included in tool (e.g. demographic information, benefit design, status of deductibles, coinsurance, account balances [HRA, HSA], copayments, provider preferences [e.g. name, gender, experience], treatment preferences, EHR, historical usage, and user-generated notes) is **accurate** and **real time**.

☐ ☐ **Rationale for missing information**
When accurate information is not available, the tool provides an easy-to-understand explanation.

CONSUMER EXPERIENCE				
CORE SPECIFICATIONS			EXPANDED SPECIFICATIONS	
YES	NO		YES	NO
☐	☐	Understandable to the consumer Tool is comprehensive, simple, and uses commonly understood language and symbols that make relevant information obvious and coherent to the user.	☐	☐ **Access to tool** Tool is easy to identify by users from website home-page and access is secure.
☐	☐	Technological platforms Information is accessible through web-based and mobile applications as well as through telephone customer service.	☐	☐ **Easily accessible clinical information** Treatment options and potential alternatives, including care setting options, are easy to identify and access. Also provides online treatment decision support and access to other live support.
		If ***YES***, the core specifications *are* met, consider evaluating the expanded specifications.	☐	☐ **Resources to obtain medical records** Provides consumers with resources to obtain their personal medical information and the ability to keep it current to help consumers personally manage their care and assist in decision-making.
			☐	☐ **Printability** Displays and information are available in a printable (e.g. PDF) format.
		If *NO*, the core specifications *are not* met, talk to your vendor or consider other tool options.	☐	☐ **Integrates decision support with financial and benefit options** Connects information to other relevant resources when members are considering care options, including but not limited to, open enrollment, benefit coverage materials, health-risk assessments, customer support, etc.
			☐	☐ **Accommodates all consumers** Accommodates individuals with special needs and/or limited technological access.

DATA EXCHANGE, REPORTING AND EVALUATION

CORE SPECIFICATIONS			EXPANDED SPECIFICATIONS	
YES	NO		YES	NO
☐	☐	Claims data access Contracts between health plans and purchasers have no restrictions on a purchaser's access to their claims data (within the scope of all relevant privacy laws) and book of business rates for any given service or bundle of services paid to any provider or network of providers.	☐	☐ **Data Format** Data are maintained by the health plan or third-party vendor for future purposes, including audits and regular tool improvement.
☐	☐	Data sharing with other vendors Contracts between purchasers and plans should permit the purchaser to receive claims data from the plan and share that data with any third-party vendor to develop consumer transparency tools or to assist with data interpretation.	☐	☐ **Utilization Reporting (Quality and Savings)** Vendors should prepare reports to the purchaser during agreed upon intervals on the utilization of quality and savings information. Quality reports should include data on consumers' use of quality-related resources available in the tool. Savings reports should include information on the accuracy of the price data, and measure/evaluate a purchaser's specific savings attributable to consumers' use of the tool. Such reports should also identify opportunities to overcome barriers to utilization and efficacy.
			☐	☐ Tool evolution Vendors routinely monitor the use of the transparency tool and make improvements based on usage data and feedback from users. Vendors should also update the tool based on online consumer trends.

If ***YES***, the core specifications *are* met, consider evaluating the expanded specifications.

If *NO*, the core specifications *are not* met, talk to your vendor or consider other tool options.

ACKNOWLEDGEMENTS

These specifications were developed after reviewing multiple sources of information and tools related to price transparency. Sources include information from: government agencies; quality organizations; other business coalitions; health plans; vendors; employer contracts; and the Catalyst for Payment Reform health plan RFI and contract language.

CATALYST FOR PAYMENT REFORM

Report Card on State Price Transparency Laws

March 18, 2013

CATALYST FOR PAYMENT REFORM

HEALTH CARE INCENTIVES IMPROVEMENT INSTITUTE

Dear Colleagues,

As health care costs continue to rise, consumers are increasingly being required to take on a growing share. To underscore that point, the most recent survey by Mercer shows that close to two-thirds of all large employers offer a high deductible/high co-insurance health plan and that close to 20 percent of all commercially insured health plan members are enrolled in such plans. In this environment, it is only fair and logical to ensure that consumers have the necessary quality and price information to make informed decisions about where to seek health care. We have made progress sharing information about the quality of care, with organizations like Bridges to Excellence and The Leapfrog Group leading the way and federal and state governments getting in on the act. But with recent studies showing us that the price for an identical procedure within a market can vary seven-fold with no demonstrable difference in quality, price transparency is more important than ever.

While the private sector has made progress recently in making prices more available to consumers, there are still large gaps. States can play an important role in ensuring that consumers have access to both quality and price information by setting policies and implementing laws that advance transparency. The most comprehensive, consumer-friendly laws ensure ready access to information and data about a broad range of providers and services.

This Report Card on State Price Transparency Laws represents a joint effort between Catalyst for Payment Reform and the Health Care Incentives Improvement Institute to examine existing transparency laws in all 50 states and grade them, using well-defined criteria, on how well they support the information needs of consumers. The Methodology section of this report contains detail about these criteria.

We hope the Report Card will inform advocates, lawmakers and policy experts about today's best practices or what constitutes a top grade and, over time, generate improvements in public policies across the nation. American consumers deserve to have as much information about the quality and price of their health care as they do about restaurants, cars, and household appliances.

Sincerely,

Francois de Brantes, MS, MBA
Executive Director
Health Care Incentives Improvement Institute

Suzanne Delbanco, Ph.D.
Executive Director
Catalyst for Payment Reform

I. METHODOLOGY

Catalyst for Payment Reform (CPR) and the Health Care Incentives Improvement Institute (HCI³) teamed up to review state-specific laws focused on price transparency for health care. The review generated two products: (1) a Report Card on State Price Transparency Laws and (2) a reference table that provides the details of the price transparency laws for each state.

CPR and HCI³ examined statutes and enacted bills using WestLawNext database, the National Conference on State Legislature's website, and websites from various state legislatures, among other sources.

This research revealed a wide variety of state laws, with two common and critical elements: (1) varying levels of price information and (2) varying levels of public access to that information. Using that continuum, the research team established levels of price transparency and scoring criteria.

Levels of Price Transparency:

- Pricing information reported to the State only
- Pricing information available upon request by an individual consumer
- Pricing information available in a public report
- Pricing information available via a public website

Scoring Criteria:

- Scope of price: including charges, average charge, amount paid by the insurer and amount paid by the consumer (allowed amount)
- Scope of services covered under the law including: all medical services, inpatient services only, outpatient services only or the most common inpatient and outpatient services
- Scope of providers affected by the law including: hospitals, physicians, and surgical centers

Next, the team developed a scoring matrix (shown on following page), which allocates points based on level of price transparency and scope of price, services, and providers.

We evaluated each level of price transparency laws for scope of price, services, and providers. For example, if laws required pricing information (both paid amounts and charges) to be posted on a public website for all inpatient and outpatient services across all hospitals and providers, the state received full credit (50 out of 50 possible points) for that level of transparency. However, if the laws required only charges to be posted for the most common hospital discharges across a subset of hospitals, the state received substantially fewer points (15 out of 50 possible points). We calculated a score for each level separately and then summed for a total score out of 100 possible points. Every state received a cumulative additive score, taking into account all relevant laws passed in that state. Thus, grades do not reflect individual statutes or bills but rather each state's overall legislative effort toward price transparency for health care.

The objective of this research was to determine how much pricing information each state makes accessible to the consumer. As a result, we allocated more points to states with laws requiring that information be posted on a public website than to those with provisions for releasing a public report, making the information available upon request, and only

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Special thanks to Elizabeth Bailey, MPH, Program Implementation Leader, HCI3, and Emilio Galan, Special Initiatives Analyst, Catalyst for Payment Reform, for their research and dedication to this project.

specific to both what was paid for a service and what was charged for that service is more meaningful than only releasing what was charged. Charges often are of little value to consumers; the amount that is actually paid for the service, particularly the amount that the consumer is responsible for paying, provides the most actionable information. Similarly, releasing pricing information for all inpatient and outpatient services and for all hospitals and providers, rather than just the most common services or a subset of providers, is more meaningful to the consumer. As a result, we allotted a higher point value to the broader scope of services/providers.

				SUBTOTAL	TOTAL	GRADE
Provision for publishing a report to the state only			**1 (weight)**			
Scope of Price Legislated (three levels, can only have 1 score out of 3)	Paid Amounts and Charges	4				
	Paid Amounts	3	4			
	Charges	1				
Scope of Services Legislated (three levels, can only have 1 score out of 3)	All IP and OP	3				
	All IP or OP	2	3	10		
	Most common IP or OP	1				
Scope of Health Care Providers Legislated (three levels, can only have 1 score out of 3)	All hospitals and providers	3				
	All hospitals or providers	2	3			
	Subset of hospitals/providers	1				
Ability for patient to request pricing information prior to rendering of services			**2 (weight)**			
Scope of Price Legislated (three levels, can only have 1 score out of 3)	Paid Amounts and Charges	4				
	Paid Amounts	3	8			
	Charges	1				
Scope of Services Legislated (three levels, can only have 1 score out of 3)	All IP and OP	3				
	All IP or OP	2	6	20		
	Most common IP or OP	1				
Scope of Health Care Providers Legislated (three levels, can only have 1 score out of 3)	All hospitals and providers	3				
	All hospitals or providers	2	6			
	Subset of hospitals/providers	1				
Provision for publishing a public report on pricing information			**2 (weight)**		100	A
Scope of Price Legislated (three levels, can only have 1 score out of 3)	Paid Amounts and Charges	4				
	Paid Amounts	3	8			
	Charges	1				
Scope of Services Legislated (three levels, can only have 1 score out of 3)	All IP and OP	3				
	All IP or OP	2	6	20		
	Most common IP or OP	1				
Scope of Health Care Providers Legislated (three levels, can only have 1 score out of 3)	All hospitals and providers	3				
	All hospitals or providers	2	6			
	Subset of hospitals/providers	1				
Provision for posting pricing information on a public website			**5 (weight)**			
Scope of Price Legislated (three levels, can only have 1 score out of 3)	Paid Amounts and Charges	4				
	Paid Amounts	3	20			
	Charges	1				
Scope of Services Legislated (three levels, can only have 1 score out of 3)	All IP and OP	3				
	All IP or OP	2	15	50		
	Most common IP or OP	1				
Scope of Health Care Providers Legislated (three levels, can only have 1 score out of 3)	All hospitals and providers	3				
	All hospitals or providers	2	15			
	Subset of hospitals/providers	1				

While no state has implemented laws that meet all of our criteria, we graded on a curve to acknowledge the states with the most advanced laws to date. We anticipate that this curve will shift as transparency becomes more of a priority nationally. We based the letter grades on the following scores:

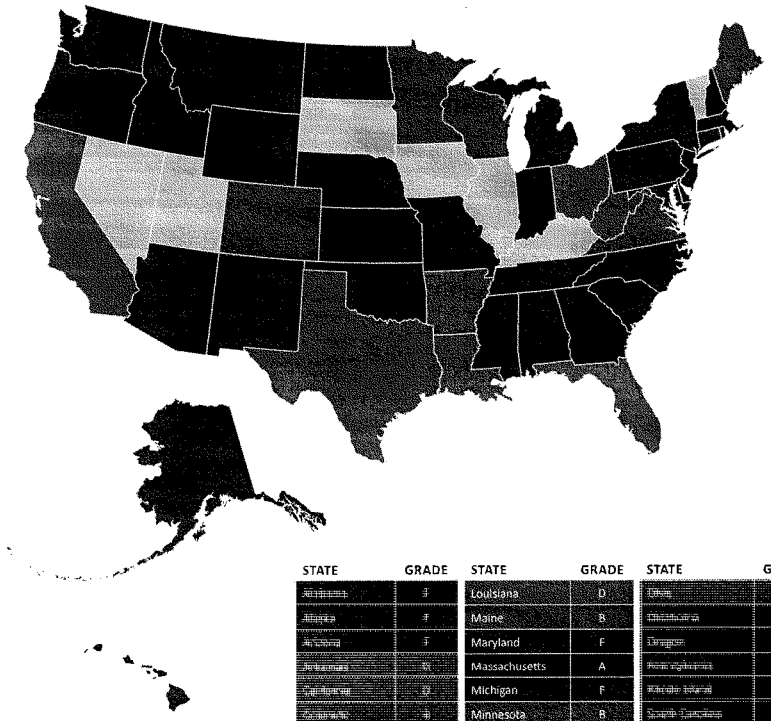
GRADE	FROM	TO
A	[illegible]	[illegible]
B	[illegible]	[illegible]
C	[illegible]	[illegible]
F	0%	[illegible]

Limitations of this research include (1) variation in definitions among states and (2) accounting for the difference between laws and execution. Numerous permutations exist in the ways states define terms, such as the term "health care provider" or what is included in a "public report." Many times these public reports, even when developed for the explicit purpose of enabling consumers to make informed decisions, do not contain the resolution of information needed to understand a specific provider's price. Instead, public reports may contain aggregate or average charges for all providers for a specific service. Interested readers should refer to the statute text and example reports, which are hyperlinked in the "Reference Table." The second limitation is accounting for the difference between laws and execution. A website intended for consumer use may be legislated but not easily identifiable or actionable, while in other cases, such a website was not legislated but nonetheless developed by the state or an independent party, often the state's hospital association. These considerations were addressed on a state by state basis with all relevant details present or hyperlinked in the Reference Table.

Resources permitting, CPR and HCI[3] will partner again next year to update this state report card. We anticipate that we will raise the scoring thresholds for each letter grade at that time.

II. 50 STATE REPORT CARD ON PRICE TRANSPARENCY LAWS

Figure 1: Map Overlay



STATE	GRADE
[illegible]	F
[illegible]	F
[illegible]	F
[illegible]	[illegible]
[illegible]	D
[illegible]	B
[illegible]	F
[illegible]	F
[illegible]	B
[illegible]	F
[illegible]	F
[illegible]	F
[illegible]	F
[illegible]	F
[illegible]	F
[illegible]	F
[illegible]	F

STATE	GRADE
Louisiana	D
Maine	B
Maryland	F
Massachusetts	A
Michigan	F
Minnesota	B
Mississippi	F
Missouri	F
Montana	F
Nebraska	F
[illegible]	[illegible]
New Hampshire	A
New Jersey	F
New Mexico	F
New York	F
North Carolina	F
North Dakota	F

STATE	GRADE
[illegible]	D
[illegible]	B
[illegible]	F
[illegible]	A
[illegible]	F
[illegible]	B
[illegible]	F
[illegible]	[illegible]
[illegible]	F
[illegible]	F
[illegible]	[illegible]
[illegible]	F
[illegible]	F
[illegible]	F
[illegible]	F
[illegible]	F

III. SIMPLIFIED SCORING AND GRADES BY STATE

		Scope of Providers			Scope of Price			Scope of Services			
State	Level of Transparency	Both Practitioners & Facilities	Health Care Practitioner or Facility	Subset of Either Practitioner or Facility	Both	Paid Amounts	Charges	All IP & OP	All IP or OP	Most common IP or OP	Grade
AK	State Only										F
	Upon Request										
	Report										
	Website										
AL	State Only										F
	Upon Request										
	Report										
	Website										
AR	State Only		✓				✓			✓	D
	Upon Request										
	Report		✓				✓			✓	
	Website		✓				✓			✓	
AZ	State Only			✓			✓		✓		F
	Upon Request		✓				✓			✓	
	Report			✓			✓		✓		
	Website										
CA	State Only		✓				✓	✓		✓	D
	Upon Request			✓			✓	✓		✓	
	Report										
	Website		✓				✓			✓	
CO	State Only			✓		✓	✓			✓	B
	Upon Request		✓				✓			✓	
	Report										
	Website		✓	✓		✓	✓			✓	
CT	State Only	✓				✓	✓		✓		F
	Upon Request	✓					✓			✓	
	Report										
	Website										
DE	State Only		✓				✓		✓		F
	Upon Request										
	Report		✓				✓		✓		
	Website										
FL	State Only		✓				✓		✓		D
	Upon Request			✓			✓			✓	
	Report										
	Website		✓				✓			✓	
GA	State Only	✓					✓		✓		F
	Upon Request										
	Report										
	Website										
HI	State Only										F
	Upon Request										
	Report										
	Website										

State	Level of Transparency	Scope of Providers			Scope of Price			Scope of Services			Grade
		Both Practitioners & Facilities	Health Care Practitioner or Facility	Subset of Either Practitioner or Facility	Both	Paid Amounts	Charges	All IP & OP	All IP or OP	Most common IP or OP	
IA	State Only		✓				✓	✓			C
	Upon Request										
	Report										
	Website		✓				✓	✓		✓	
ID	State Only										F
	Upon Request										
	Report										
	Website										
IL	State Only		✓				✓	✓			C
	Upon Request		✓				✓		✓		
	Report		✓				✓	✓			
	Website		✓				✓			✓	
IN	State Only		✓				✓		✓		F
	Upon Request		✓				✓		✓		
	Report		✓				✓		✓		
	Website										
KS	State Only	✓					✓		✓		F
	Upon Request										
	Report										
	Website										
KY	State Only	✓					✓		✓		C
	Upon Request										
	Report	✓					✓		✓		
	Website	✓					✓		✓		
LA	State Only	✓					✓		✓		D
	Upon Request										
	Report										
	Website	✓					✓		✓		
MA	State Only	✓			✓			✓			A
	Upon Request				✓				✓		
	Report		✓				✓	✓			
	Website	✓				✓				✓	
MD	State Only		✓				✓		✓		F
	Upon Request										
	Report		✓				✓		✓		
	Website										
ME	State Only	✓			✓					✓	B
	Upon Request	✓				✓				✓	
	Report										
	Website		✓		✓					✓	
MI	State Only										F
	Upon Request										
	Report										
	Website										

State	Level of Transparency	Scope of Providers			Scope of Price			Scope of Services			Grade
		Both Practitioners & Facilities	Health Care Practitioner or Facility	Subset of Either Practitioner or Facility	Both	Paid Amounts	Charges	All IP & OP	All IP or OP	Most common IP or OP	
MN	State Only	✓			✓			✓			B
	Upon Request			✓			✓		✓		
	Report		✓				✓		✓		
	Website		✓				✓			✓	
MO	State Only										F
	Upon Request										
	Report										
	Website										
MS	State Only										F
	Upon Request										
	Report										
	Website										
MT	State Only										F
	Upon Request										
	Report										
	Website		✓				✓	✓			
NC	State Only		✓				✓			✓	F
	Upon Request		✓				✓			✓	
	Report										
	Website										
ND	State Only	✓					✓	✓			F
	Upon Request										
	Report	✓					✓			✓	
	Website										
NE	State Only										F
	Upon Request	✓					✓		✓		
	Report										
	Website										
NH	State Only	✓			✓			✓			A
	Upon Request	✓			✓					✓	
	Report										
	Website	✓			✓					✓	
NJ	State Only		✓		✓				✓		F
	Upon Request										
	Report		✓		✓				✓		
	Website										
NM	State Only		✓				✓		✓		F
	Upon Request										
	Report		✓				✓		✓		
	Website										
NV	State Only		✓				✓			✓	C
	Upon Request		✓				✓			✓	
	Report		✓				✓			✓	
	Website		✓				✓			✓	

State	Level of Transparency	Scope of Providers			Scope of Price			Scope of Services			Grade
		Both Practitioners & Facilities	Health Care Practitioner or Facility	Subset of Either Practitioner or Facility	Both	Paid Amounts	Charges	All IP & OP	All IP or OP	Most common IP or OP	
NY	State Only	✓					✓			✓	F
	Upon Request										
	Report	✓					✓			✓	
	Website										
OH	State Only		✓				✓		✓		D
	Upon Request		✓				✓			✓	
	Report										
	Website		✓				✓		✓		
OK	State Only		✓		✓				✓		F
	Upon Request										
	Report										
	Website										
OR	State Only	✓					✓		✓		F
	Upon Request										
	Report	✓					✓		✓		
	Website										
PA	State Only	✓			✓				✓		F
	Upon Request										
	Report	✓			✓				✓		
	Website										
RI	State Only	✓			✓				✓		F
	Upon Request										
	Report	✓					✓		✓		
	Website										
SC	State Only		✓				✓	✓			F
	Upon Request										
	Report		✓				✓		✓		
	Website										
SD	State Only		✓				✓		✓		C
	Upon Request		✓				✓		✓		
	Report		✓				✓			✓	
	Website		✓				✓			✓	
TN	State Only	✓					✓	✓			F
	Upon Request										
	Report	✓					✓	✓			
	Website										
TX	State Only	✓					✓	✓			D
	Upon Request	✓					✓	✓			
	Report	✓					✓	✓			
	Website										
UT	State Only	✓					✓		✓		C
	Upon Request										
	Report	✓					✓		✓		
	Website	✓					✓		✓		

State	Level of Transparency	Scope of Providers			Scope of Price			Scope of Services			Grade
		Both Practitioners & Facilities	Health Care Practitioner or Facility	Subset of Either Practitioner or Facility	Both	Paid Amounts	Charges	All IP & OP	All IP or OP	Most common IP or OP	
VA	State Only	✓			✓			✓			B
	Upon Request										
	Report	✓			✓				✓		
	Website	✓					✓			✓	
VT	State Only	✓					✓	✓			C
	Upon Request										
	Report	✓					✓			✓	
	Website	✓					✓			✓	
WA	State Only										F
	Upon Request	✓					✓	✓			
	Report										
	Website										
WI	State Only				✓				✓		B
	Upon Request	✓					✓	✓			
	Report		✓				✓		✓		
	Website		✓				✓			✓	
WV	State Only	✓					✓		✓		D
	Upon Request		✓				✓	✓			
	Report	✓					✓		✓		
	Website										
WY	State Only										F
	Upon Request										
	Report										
	Website		✓				✓	✓			

STATE LAWS ON HEALTH CARE PRICE TRANSPARENCY AND DISCLOSURE											
			SCOPE OF HEALTH CARE PROVIDERS		SCOPE OF PRICE		SCOPE OF SERVICES		LEVEL OF TRANSPARENCY		
STATE	LAWS	YEAR	Scope of Health Care Providers	Insurers are required to report? (Not factored in scoring)	Charges	Paid Amounts	Scope of Services	Reported to the State	Available upon request	Available in Report	Available on Website
Description	Relevant statute(s) with a hyperlink to the text and all relevant enacted bills with available hyperlinks	If available, date of enactment	May legislate hospitals, surgical centers, or all providers including individual physicians	May legislate health plans, insurers, or carriers to report to the state	Includes average annual charges, charge estimates, actual charges	Demonstrates accepted reimbursement rates from different payers	May legislate only most common procedures, only outpatient services, or all billable services	Price information is reported to the state	Price information is available to an individual upon request	Price information is available in a publicly available report	Price information is available on a website
Arizona	STATUTE(S): Arizona Revised Statutes § 36-125.05 ENACTED BILL(S): Added: 1983; Amended: S.B. 1201 (1988), S.B. 1486 (1988), S.B. 1086 (1990), S.B. 1352 (1994), H.B. 2048 (1996), S.B. 1142 (2005), H.B. 2150 (2010)	Added: 1983 Amended: 1988, 1990, 1994, 2005, 2010	"hospitals [except] state hospitals"		"The average charge per day [and] The average charge per confinement"		"all inpatient services"	"[report to] the department"		"All reports filed pursuant to this section are open to public inspection"	
	STATUTE(S): Arizona Revised Statutes § 36-125.05 ENACTED BILL(S): Added: 1983; Amended: S.B. 1201 (1988),S.B. 1486 (1988), S.B. 1086 (1990), S.B. 1352 (1994), H.B. 2048 (1996), S.B. 1142 (2005), H.B. 2150 (2010)	Added: 1983 Amended: 1988, 1990, 1996, 2005, 2010	"Emergency departments"		"Charges for services"		"outpatient services"	"[report to] the department"		"All reports filed pursuant to this section are open to public inspection"	
	STATUTE(S): Arizona Revised Statutes § 36-125.06 ENACTED BILL(S): Added: 1983; Amended: S.B. 1086 (1990), H.B. 2048 (1996), S.B. 1230 (2000), S.B. 1142 (2005)	Added: 1983 Amended: 1990, 1996, 2000, 2005	"hospitals and emergency departments"		"average charges per confinement"		"the most common diagnoses and procedures for inpatient and emergency department"		"shall make available in its reception area a sufficient number of these brochures for free distribution of one copy to each individual requesting a copy"	"The director shall publish a comparative report"	

STATE LAWS ON HEALTH CARE PRICE TRANSPARENCY AND DISCLOSURE											
			SCOPE OF HEALTH CARE PROVIDERS		SCOPE OF PRICE		SCOPE OF SERVICES		LEVEL OF TRANSPARENCY		
STATE	LAWS	YEAR	Scope of Health Care Providers	Insurers are required to report? (Not factored in grading)	Charge	Paid Amount	Scope of Services	Reported to the State	Available upon request	Available in Report	Available on Website
Description	Relevant statute(s) with a hyperlink to the text and all relevant enacted bills with available hyperlinks	If available, date of enactment	May legislate hospitals, surgical centers, or all providers including individual physicians	May legislate health plans, insurers, or carriers to report to the state	includes average annual charges, charge estimates, actual charges	Demonstrates accepted reimbursement rates from different payers	May legislate only most common procedures, only outpatient services, or all billable services	Price information is reported to the state	Price information is available to an individual upon request	Price information is available in a publicly available report	Price information is available on a website
Arizona	STATUTE(S): Arizona Revised Statutes § 36-436 ENACTED BILL(S): Added: 1971; Amended: S.B. 1355 (1989), S.B. 1352 (1994)	Added: 1971 Amended: 1989, 1994	"hospital or nursing care institution"		"schedule of its rates and charges"		"all services performed and commodities furnished"	"file [...] with the director"	"posted in a conspicuous place in the reception area of each [and] Another copy also shall be kept in the reception area and be available for inspection by the public at all times upon request"	"publish information"	
	STATUTE(S): Arizona Revised Statutes § 36-436.03 ENACTED BILL(S): Added: S.B. 1352 (1994)	Added: 1994	"A home health agency, supervisory care home and a hospice"		"a copy of the institution's rates and charges"				"to the public on request"	"report"	
Arkansas	STATUTE(S): Arkansas Code §§ 20-7-303, 4, 5 ENACTED BILL(S): Added: S.B. 596 (1995) Amended: H.B. 1470 (2005), H.B. 1513 (2007)	Added: 1995 Amended: 2005, 2007	"All hospitals and outpatient surgery centers"		"health data" AND "price [...] information"			"collected by the Division of Health of the Department of Health and Human Services"		"disseminate"	"provide data to the Arkansas Hospital Association for its price transparency and consumer-driven health care project"

STATE LAWS ON HEALTH CARE PRICE TRANSPARENCY AND DISCLOSURE											
			SCOPE OF HEALTH CARE PROVIDERS		SCOPE OF PRICE		SCOPE OF SERVICES		LEVEL OF TRANSPARENCY		
STATE	LAWS	YEAR	Scope of Health Care Providers	Insurers are required to report? (Not factored in grading)	Charge	Paid Amount	Scope of Services	Reported to the State	Available upon request	Available in Report	Available on Website
Description	Relevant statute(s) with a hyperlink to the text and all relevant enacted bills with available hyperlinks	If available, date of enactment	May legislate hospitals, surgical centers, or all providers including individual physicians	May legislate health plans, insurers, or carriers to report to the state	Includes average annual charges, charge estimates, actual charges	Demonstrates accepted reimbursement rates from different payers	May legislate only most common procedures, only outpatient services, or all billable services	Price information is reported to the state	Price information is available to an individual upon request	Price information is available in a publicly available report	Price information is available on a website
California	STATUTE(S): California Health and Safety Code §1339.51, §1339.55 ENACTED BILL(S): Added: A.B. 1627 §6 (2003)	Added: 203	"hospital[s]" except "small and rural hospital[s]"		"charge description master"				"shall make a written [...] copy available at the hospital location." AND "shall post a clear and conspicuous notice in its emergency department, if any, in its admissions office, and in its billing office that informs patients that the hospital's charge description master is available"		"[...] electronic copy [...] by posting an electronic copy [...] on the hospital's Internet Web site"
	STATUTE(S): California Health and Safety Code §1339.56 ENACTED BILL(S): Added: A.B. 1627 §6 (2003); Amended: by A.B. 1045 §1 (2005)	Added: 2003	"each hospital"		"average charges"		"25 common outpatient procedures" and "25 most commonly performed inpatient procedures"	"submit annually to the office"	"shall provide a copy [...] to any person upon request"		"the office shall publish this information on its Internet Web site"

STATE LAWS ON HEALTH CARE PRICE TRANSPARENCY AND DISCLOSURE											
			SCOPE OF HEALTH CARE PROVIDERS		SCOPE OF PRICE		SCOPE OF SERVICES		LEVEL OF TRANSPARENCY		
			Scope of [...] Health Care Providers	Insurers are required to report? (Not factored in grading)	Charge	Paid Amount	Scope of Services	Reported to the State	Available upon request	Available in Report	Available on Website
STATE	Laws	YEAR									
Description	Relevant statute(s) with a hyperlink to the text and all relevant enacted bills with available hyperlinks	If available, date of enactment	May legislate hospitals, surgical centers, or all providers including individual physicians	May legislate health plans, insurers, or carriers to report to the state	Includes average annual charges, charge estimates, actual charges	Demonstrates accepted reimbursement rates from different payers	May legislate only most common procedures, only outpatient services, or all billable services	Price information is reported to the state	Price information is available to an individual upon request	Price information is available in a publicly available report	Price information is available on a website
California	STATUTE(S): California Health and Safety Code §1339.585 ENACTED BILL(S): Added: A.B. 1045 §1 (2005)	Added: 2005	"hospital"		"written estimate of the amount the hospital will require the person to pay [...] based on an average length of stay and services provided for the person's diagnosis"		"for health care services, procedures, and supplies [...] does not apply to emergency services"		"Upon the request of a person without health coverage"		
	STATUTE(S): California Health and Safety Code §128735 ENACTED BILL(S): Added: S.B. 1360 §5 (1995); Amended: S.B. 1659 §2 (1996), S.B. 1973 §8 (1998), S.B. 680 §2 (2001), S.B. 1498 §163 (2008)	Added: 1995 Amended: 1996, 1998, 2001, 2008	"Every organization that operates, conducts, or maintains a health facility"		"Total charges"			"submit annually to the office"			
Colorado	STATUTE(S): Colorado Revised Statutes §10-16-133 ENACTED BILL(S): Added: H.B. 08-1385 §1 (2008)	Added: 2008		"each carrier"	"information [...] useful to consumers and purchasers of health care insurance"				"alternative methods of making the consumer guide accessible to consumers who do not have internet access"		"maintain a consumer guide on the division of insurance web site"

STATE LAWS ON HEALTH CARE PRICE TRANSPARENCY AND DISCLOSURE											
			SCOPE OF HEALTH CARE PROVIDERS		SCOPE OF PRICE		SCOPE OF SERVICES		LEVEL OF TRANSPARENCY		
STATE	LAWS	YEAR	Scope of Health Care Providers	Insurers are required to report? (Not factored in grading)	Charge	Paid Amount	Scope of Services	Reported to the State	Available upon request	Available in Report	Available on Website
Description	Relevant statute(s) with a hyperlink to the text and all relevant enacted bills with available hyperlinks	If available, date of enactment	May legislate hospitals, surgical centers, or all providers including individual physicians	May legislate health plans, insurers, or carriers to report to the state	Includes average annual charges, charge estimates, actual charges	Demonstrates accepted reimbursement rates from different payers	May legislate only most common procedures, only outpatient services, or all billable services	Price information is reported to the state	Price information is available to an individual upon request	Price information is available in a publicly available report	Price information is available on a website
Colorado	STATUTE(S): Colorado Revised Statutes §10-16-111 §1 ENACTED BILL(S): Added: S.B. 92-104 §1 (1992); Amended: S.B. 92-90 §113 (1992)	Added: 1992 Amended: 1992	"Nonprofit hospital, medical-surgical, and health service corporations"	"all insurance companies"		"amounts actually paid"	"for hospital, medical-surgical, and other health services"	"file annually with the commissioner"			
	STATUTE(S): Colorado Revised Statutes §10-16-111 §4 ENACTED BILL(S): Added: H.B. 08-1389 §9 (2008)	Added: 2008		"all carriers"	"medical provider price increases" AND "pharmaceutical price increases"	"The cost of providing or arranging health care services"		"file annually with the commissioner"			"publish the information on the division's web site"
	STATUTE(S): Colorado Revised Statutes §25.5-6-202 ENACTED BILL(S): Added: S.B. 06–219 (2006); Amended: H.B. 08–1114 (2008), S.B. 09-263 (2009), H.B. 10-1324 (2010), H.B. 10-1379 (2010), S.B. 11-215 (2011), H.B. 12-1340 (2012)	Added: 2006 Amended: 2009, 2010, 2011, 2012	"each nursing facility provider"		"cost reports"			"filed with the state department"			
	STATUTE(S): Colorado Revised Statutes §6-20-101 ENACTED BILL(S): Added: S.B. 03-015 (2003); Amended: S.B. 04-239 (2004)	Added: 2003 Amended: 2011	"each hospital"		"Average facility charge [...] the average charge information"		"Frequently performed inpatient procedure" (explicitly excludes emergency care)		"disclose to a person seeking care or treatment"		

STATE LAWS ON HEALTH CARE PRICE TRANSPARENCY AND DISCLOSURE											
			SCOPE OF HEALTH CARE PROVIDERS		SCOPE OF PRICE		SCOPE OF SERVICES		LEVEL OF TRANSPARENCY		
STATE	LAWS	YEAR	Scope of Health Care Providers	Insurers are required to report? (Not factored in grading)	Charge	Paid Amount	Scope of Services	Reported to the State	Available upon request	Available in Report	Available on Website
Description	Relevant statute(s) with a hyperlink to the text and all relevant enacted bills with available hyperlinks	If available, date of enactment	May legislate hospitals, surgical centers, or all providers including individual physicians	May legislate health plans, insurers, or carriers to report to the state	Includes average annual charges, charge estimates, actual charges	Demonstrates accepted reimbursement rates from different payers	May legislate only most common procedures, only outpatient services, or all billable services	Price information is reported to the state	Price information is available to an individual upon request	Price information is available in a publicly available report	Price information is available on a website
Colorado	STATUTE(S): Colorado Revised Statutes §25-3-705 ENACTED BILL(S): Added: H.B. 08-1393 (2008); Amended: H.B. 1303 (2011)	Added: 2008 Amended: 2011	"each hospital"		"Mean charge"		"the top twenty-five diagnostic-related groups with more than ten occurrences"	"shall report annually to the association of hospitals"			"division of insurance web site" AND "shall be made available on the [Colorado Hospital Association's] web site in a manner that allows consumers to conduct an interactive search to view and compare the information for specific hospitals"
	STATUTE(S): Colorado Revised Statutes §10-16-134 ENACTED BILL(S): Added: H.B. 08-1393 (2008)	Added: 2008		"each carrier"		"average reimbursement rates"	"for the average inpatient day [...]the twenty-five most common inpatient procedures"	"submit to the division"			"division of insurance web site" AND "shall ensure that the [Colorado Hospital Association's] web site and information is easy to navigate, contains consumer-friendly language"

STATE LAWS ON HEALTH CARE PRICE TRANSPARENCY AND DISCLOSURE											
			SCOPE OF HEALTH CARE PROVIDERS		SCOPE OF PRICE		SCOPE OF SERVICES		LEVEL OF TRANSPARENCY		
STATE	LAWS	YEAR	Scope of Health Care Providers	Insurers are required to report? (Not factored in grading)	Charge	Paid Amount	Scope of Services	Reported to the State	Available upon request	Available in Report	Available on Website
Description	Relevant statute(s) with a hyperlink to the text and all relevant enacted bills with available hyperlinks	If available, date of enactment	May legislate hospitals, surgical centers, or all providers including individual physicians	May legislate health plans, insurers, or carriers to report to the state	Includes average annual charges, charge estimates, actual charges	Demonstrates accepted reimbursement rates from different payers	May legislate only most common procedures, only outpatient services, or all billable services	Price information is reported to the state	Price information is available to an individual upon request	Price information is available in a publicly available report	Price information is available on a website
Connecticut	STATUTE(S): Connecticut General Statutes §20-7a ENACTED BILL(S): Added: 1973 Amended: S.H.B. 7214 (1991), S.H.B. 5139 (1992), S.H.B. 6713 (2005), S.H.B. 5820 (2006), H.B. 6678 (2009), H.B. 5292 (2010)	Added: 1973 Amended: 1991, 1992, 2005, 2006, 2009, 2010	"Any practitioner of the healing arts who agrees with a clinical laboratory, either private or hospital, to make payments to such a laboratory for [patients'] tests..."		"amounts charged by such laboratory for individual tests or test series and the amount of his procurement or processing charge"				"shall disclose on the bills to patients or third party payors"		
	STATUTE(S): Connecticut General Statutes §20-7b ENACTED BILL(S): Added: 1973 Amended: S.H.B. 7214 (1991), S.H.B. 5139 (1992), S.H.B. 6713 (2005), S.H.B. 5820 (2006), H.B. 6678 (2009), H.B. 5292 (2010)	Added: 1973 Amended: 1991, 1992, 2005, 2006, 2009, 2010	"Each practitioner of the healing arts"		"approximate range of costs"		"test[s] to aid in the diagnosis"		"inform the patient"		
	STATUTE(S): Connecticut General Statutes §19a-613 ENACTED BILL(S): Added: H.B. 6002 (1994); Amended: H.B. 6002 (1994), S.B. 1164 (1995), S.B. 572 (1998), S.B. 547 (1998), S.B. 1373 (1999), H.B 6802 (2009)	Added: 1994 Amended: 1994, 1995, 1998, 1999, 2009	"health care facilities or institutions"		"Patient-level outpatient data"		"outpatient data"	Collected by "The Office of Health Care Access"			

STATE LAWS ON HEALTH CARE PRICE TRANSPARENCY AND DISCLOSURE											
			SCOPE OF HEALTH CARE PROVIDERS		SCOPE OF PRICE		SCOPE OF SERVICES	LEVEL OF TRANSPARENCY			
STATE	LAWS	YEAR	Scope of Health Care Providers	Insurers are required to report? (Not factored in grading)	Charges	Paid Amount	Scope of Services	Reported to the State	Available upon request	Available in Report	Available on Website
Description	Relevant statute(s) with a hyperlink to the text and all relevant enacted bills with available hyperlinks	If available, date of enactment	May legislate hospitals, surgical centers, or all providers including individual physicians	May legislate health plans, insurers, or carriers to report to the state	Includes average annual charges, charge estimates, actual charges	Demonstrates accepted reimbursement rates from different payers	May legislate only most common procedures, only outpatient services, or all billable services	Price information is reported to the state	Price information is available to an individual upon request	Price information is available in a publicly available report	Price information is available on a website
Connecticut	STATUTE(S): Connecticut General Statutes §19a-646 ENACTED BILL(S): Added: 1984; Amended: H.B. 6002 (1994), S.B. 1164 (1995), S.H.B. 5154 (2002), H.B. 5321 (2012)	Added: 1984 Amended: 1994, 1995, 2012	"the hospital"		"charges"	"payments for each payer"		"reported as required by the office"		Unlegislated report	
	STATUTE(S): Connecticut General Statutes §19a-649 ENACTED BILL(S): Added: 1958, S.H.B.7290 (1989); Amended: S.H.B. 7214 (1991), S.H.B. 6949 (1993), S.H.B. 7079 (1993), H.B. 6678 (2009), H.B. 5321 (2012)	Added: 1958, 1989 Amended: 1991, 1993, 1993, 2009, 2012	"Each hospital"		"the total and average charges and costs"		"of charity care and reduced cost services provided"	"report [to the office]"		Unlegislated report	
	STATUTE(S): Connecticut General Statutes §§19a-644, 19a-654 ENACTED BILL(S): Added: 1958, S.H.B.7290 (1989); Amended: S.H.B. 7214 (1991), S.H.B. 6949 (1993), S.H.B. 7079 (1993), H.B. 6678 (2009), H.B. 5321 (2012)	Added: 1958, 1989 Amended: 1991, 1993, 2009, 2012	"short-term acute care general or children's hospitals"		"discharge data [...] from medical record abstracts and hospital bills"			"submit [to the] office"		Unlegislated report	

STATE LAWS ON HEALTH CARE PRICE TRANSPARENCY AND DISCLOSURE											
			SCOPE OF HEALTH CARE PROVIDERS		SCOPE OF PRICE		SCOPE OF SERVICES		LEVEL OF TRANSPARENCY		
STATE	LAWS	YEAR	Scope of Health Care Providers	Insurers are required to report? (Not factored in grading)	Charge	Paid Amount	Scope of Service	Reported to the state	Available upon request	Available in Report	Available on Website
Description	Relevant statute(s) with a hyperlink to the text and all relevant enacted bills with available hyperlinks	If available, date of enactment	May legislate hospitals, surgical centers, or all providers including individual physicians	May legislate health plans, insurers, or carriers to report to the state	Includes average annual charges, charge estimates, actual charges	Demonstrates accepted reimbursement rates from different payers	May legislate only most common procedures, only outpatient services, or all billable services	Price information is reported to the state	Price information is available to an individual upon request	Price information is available in a publicly available report	Price information is available on a website
Connecticut	STATUTE(S): Connecticut General Statutes §19a-681 ENACTED BILL(S): Added: H.B. 7030 (1995); Amended: S.B. 1145 (2005), S.B. 622 (2008), S.B. 494 (2010)	Added: 1995 Last Amended: 2005, 2008, 2010	"Each hospital"		"current price-master which shall include each charge in its detailed schedule of charges"			"shall file with the office"			
Delaware	STATUTE(S): Delaware Code §2003 ENACTED BILL(S): Added: 1989; Amended: H.B. 507 (1994), S.B. 47 (2009)	Added: 1989 Amended: 1994, 2009	"Hospitals and nursing homes"	"Charge levels [and] trends in health care charges"				"submitted by all [...] to the state agency"		"state agency shall prepare and distribute or make available reports to health care purchasers, health care insurers, health care providers and the general public"	
	STATUTE(S): Delaware Code Ann. §§2004, 2006 ENACTED BILL(S): Added: 1989; Amended: H.B. 507 (1994), S.B. 235 (2008)	Added: 1989 Amended: 1994, 2009	"all hospitals [and] all nursing home"				"all hospital [and] nursing home inpatient discharges"	"submitted by all [...] to the state agency"		"All compilations prepared and authorized by the state agency for release and dissemination shall be public records"	

STATE LAWS ON HEALTH CARE PRICE TRANSPARENCY AND DISCLOSURE											
			SCOPE OF HEALTH CARE PROVIDERS		SCOPE OF PRICE		SCOPE OF SERVICES		LEVEL OF TRANSPARENCY		
STATE	LAWS	YEAR	Scope of Health Care Provider	Insurers are required to report? (Not factored in grading)	Charge	Paid Amount	Scope of Services	Reported to the State	Available upon request	Available in Report	Available on Website
Description	Relevant statute(s) with a hyperlink to the text and all relevant enacted bills with available hyperlinks	If available, date of enactment	May legislate hospitals, surgical centers, or all providers including individual physicians	May legislate health plans, insurers, or carriers to report to the state	Includes average annual charges, charge estimates, actual charges	Demonstrates accepted reimbursement rates from different payers	May legislate only most common procedures, only outpatient services, or all billable services	Price information is reported to the state	Price information is available to an individual upon request	Price information is available in a publicly available report	Price information is available on a website
Florida	STATUTE(S): Florida Statutes §381.026 ENACTED BILL(S): Added: S.B. 292 (1991), H.B. 367–H (1992), S.B. 598 (1995); Amended: C.S.H.B. 475 (2001), S.B. 1324 (2001), H.B. 1629 (2004), H.B. 7073 (2006), S.B. 1488 (2008), H.B. 155 (2011), H.B. 935 (2011), H.B. 7007 (2012)	Added; 1991, 1992, 1995 Amended: 1998, 1999, 2001, 2004, 2006, 2008, 2009, 2011, 2012	"primary care provider"		"schedule of charges [...] the schedule must include the prices charged to an uninsured person"		"must include, but is not limited to, the 50 services most frequently provided"		"posted in a conspicuous place in the reception area"		
	STATUTE(S): Florida Statutes §381.026 ENACTED BILL(S): Added: S.B. 292 (1991), H.B. 367–H (1992), S.B. 598 (1995); Amended: C.S.H.B. 475 (2001), S.B. 1324 (2001), H.B. 1629 (2004), H.B. 7073 (2006), S.B. 1488 (2008), H.B. 155 (2011), H.B. 935 (2011), H.B. 7007 (2012)	Added; 1991, 1992, 1995 Amended: 1998, 1999, 2001, 2004, 2006, 2008, 2009, 2011, 2012	"health care provider or a health care facility shall"		"a reasonable estimate of charges				"furnish a person [...] before the provision of a planned nonemergency medical service"		

STATE LAWS ON HEALTH CARE PRICE TRANSPARENCY AND DISCLOSURE											
			SCOPE OF HEALTH CARE PROVIDERS		SCOPE OF PRICE		SCOPE OF SERVICES		LEVEL OF TRANSPARENCY		
			Scope of Health Care Providers	Insurers are required to report? (Not factored in grading)	Charge	Paid Amount	Scope of Services	Reported to the State	Available upon request	Available in Report	Available on Website
STATE	LAWS	YEAR									
Description	Relevant statute(s) with a hyperlink to the text and all relevant enacted bills with available hyperlinks	If available, date of enactment	May legislate hospitals, surgical centers, or all providers including individual physicians	May legislate health plans, insurers, or carriers to report to the state	Includes average annual charges, charge estimates, actual charges	Demonstrates accepted reimbursement rates from different payers	May legislate only most common procedures, only outpatient services, or all billable services	Price information is reported to the state	Price information is available to an individual upon request	Price information is available in a publicly available report	Price information is available on a website
Florida	STATUTE(S): Florida Statutes §395.301 ENACTED BILL(S): Added: H.B. 367–H (1992), S.B. 598 (1995) Amended: S.B. 2128 (1998), H.B. 1629 (2004), H.B. 7073 (2006), S.B. 1488 (2008)	Added: 1982, 1991, 1992, 1995 Amended: 1998, 2004, 2006, 2008	"Each licensed facility not operated by the state"		"good faith estimate of reasonably anticipated charges [...] The estimate may be the average charges for that diagnosis related group or the average charges for that procedure"		"any non-emergency medical services"		"upon request from the patient"		
	STATUTE(S): Florida Statutes §395.107 ENACTED BILL(S): Added: H.B. 935 (2011); Amended: H.B. 787 (2012)	Added: 2011 Amended: 2012	"urgent care center [and] affiliated facility"		"schedule of charges"		"no fewer than 150 of the most commonly performed adult and pediatric procedures, including outpatient, inpatient, diagnostic, and preventative procedures"		"publish [and] posted in a conspicuous place in the reception area"		
	STATUTE(S): Florida Statutes §408.05 ENACTED BILL(S): Added: H.B.1673 (1988); Amended: C.S.S.B. 314 (1998), H.B. 1053 (1999), S.B. 1766 (2000), S.B. 2568 (2003), H.B. 1629 (2004), H.B. 763 (2005), H.B. 7073 (2006), S.B. 1488 (2008), S.B. 1784 (2010)	Added: 1988, 1990, 1991, 1992, 1995, 1997 Amended: 1998, 1999, 2000, 2003, 2004, 2005, 2006, 2007, 2008, 2010	"health care facilities"		"undiscounted charges"		"no fewer than 150 of the most commonly performed adult and pediatric procedures"				"Publish on its website"

STATE LAWS ON HEALTH CARE PRICE TRANSPARENCY AND DISCLOSURE											
			SCOPE OF HEALTH CARE PROVIDERS		SCOPE OF PRICE		SCOPE OF SERVICES	LEVEL OF TRANSPARENCY			
STATE	LAWS	YEAR	Scope of Health Care Providers	Insurers are required to report? (Not factored in grading)	Charge	Paid Amount	Scope of Services	Reported to the State	Available upon request	Available in Report	Available on Website
Description	Relevant statute(s) with a hyperlink to the text and all relevant enacted bills with available hyperlinks	If available, date of enactment	May legislate hospitals, surgical centers, or all providers including individual physicians	May legislate health plans, insurers, or carriers to report to the state	Includes average annual charges, charge estimates, actual charges	Demonstrates accepted reimbursement rates from different payers	May legislate only most common procedures, only outpatient services, or all billable services	Price information is reported to the state	Price information is available to an individual upon request	Price information is available in a publicly available report	Price information is available on a website
Florida	STATUTE(S): Florida Statutes §408.061 ENACTED BILL(S): Added: S.B. 2390 (1992); Amended: S.B. 1914, 2006, 1784 & S.B 406 (1993), S.B. 226 (1995), S.B. 226 (1996), S.B. 430 (1997), S.B. 314 (1998), H.B. 1053 (1999), S.B. 1766 (2000), S.B. 2568 (2003), H.B. 1629 (2004), H.B. 763 (2005), H.B. 7073 (2006)	Added: 1992 Amended: 20061993, 1996, 1997, 1998, 1999, 2000, 2003, 2004, 2005, 2006	"health care facilities"		"actual charge data by diagnostic groups"			"[to the] agency"			
	STATUTE(S): Florida Statutes §408.061 ENACTED BILL(S): Added: S.B. 2390 (1992); Amended: H.B. 7073 (2006)	Added: 1992 Amended: 2006	"health insurers"		"claims [...] However [...] shall not include specific provider contract reimbursement information""			"[to the] agency"			
Georgia	STATUTE(S): Georgia Code §31-7-280 ENACTED BILL(S): Added: 1988; Amended: S.B. 433 (2008)	Added: 1988 Amended: 2008	"each health care provider"		"total charges and summary of charges by revenue code"			"submitted to the department"			

STATE LAWS ON HEALTH CARE PRICE TRANSPARENCY AND DISCLOSURE											
			SCOPE OF HEALTH CARE PROVIDERS		SCOPE OF PRICE		SCOPE OF SERVICES		LEVEL OF TRANSPARENCY		
			Scope of Health Care Providers	Insurers are required to report? (Not factored in grading)	Charge	Paid Amount	Scope of Services	Reported to the State	Available upon request	Available in Report	Available on Website
STATE	LAWS	YEAR									
Description	Relevant statute(s) with a hyperlink to the text and all relevant enacted bills with available hyperlinks	If available, date of enactment	May legislate hospitals, surgical centers, or all providers including individual physicians	May legislate health plans, insurers, or carriers to report to the state	Includes average annual charges, charge estimates, actual charges	Demonstrates accepted reimbursement rates from different payers	May legislate only most common procedures, only outpatient services, or all billable services	Price information is reported to the state	Price information is available to an individual upon request	Price information is available in a publicly available report	Price information is available on a website
Illinois	STATUTE(S): 20 Illinois Compiled Statutes §2215/4-2 (4) ENACTED BILL(S): Added: 1984; Amended: H.B. 2343 (2005), H.B. 1562 (2011), S.B. 1282 (2011), S.B. 3798 (2012)	Added: 1984 Amended: 2012	"hospitals"		"claims and encounter data"		"inpatient and outpatient claims and encounter data related to surgical and invasive procedures"	"compiled by the department"		"Publicly disclosed information must be provided in language that is easy to understand and accessible to consumers using an interactive query system"	
	STATUTE(S): Illinois Compiled Statutes §2215/4-2 (5) ENACTED BILL(S): Added: 1984; Amended: H.B. 2343 (2005); H.B. 1562 (2011); S.B. 1282 (2011); S.B. 3798 (2012)	Added: 1984 Amended: 2012	"each ambulatory surgical treatment center"		"outpatient claims and encounter data collected [...] for each patient"			"collect[ed] compile[d] by the department"		"Publicly disclosed information must be provided in language that is easy to understand and accessible to consumers using an interactive query system"	
	STATUTE(S): Illinois Compiled Statutes §2215/4-2 (6) ENACTED BILL(S): Added: 1984; Amended: H.B. 2343 (2005), H.B. 1562 (2011), S.B. 1282 (2011), S.B. 3798 (2012)	Added: 1984 Amended: 2002, 2011, 2012	"Ambulatory surgical treatment centers and hospitals"		"average charges"		"at least 30 inpatient [and] 30 outpatient conditions and procedures [...] demon-strate[ing] the highest degree of variation in patient charges and quality of care"	"compiled by the department"			"shall make available on its website the 'Consumer Guide to Care'"

STATE LAWS ON HEALTH CARE PRICE TRANSPARENCY AND DISCLOSURE											
			SCOPE OF HEALTH CARE PROVIDERS		SCOPE OF PRICE		SCOPE OF SERVICES		LEVEL OF TRANSPARENCY		
STATE	LAWS	YEAR	Scope of Health Care Providers	Insurers are required to report? (Not factored in grading)	Charge	Paid Amount	Scope of Services	Reported to the State	Available upon request	Available in Report	Available on Website
Description	Relevant statute(s) with a hyperlink to the text and all relevant enacted bills with available hyperlinks	If available, date of enactment	May legislate hospitals, surgical centers, or all providers including individual physicians	May legislate health plans, insurers, or carriers to report to the state	Includes average annual charges, charge estimates, actual charges	Demonstrates accepted reimbursement rates from different payers	May legislate only most common procedures, only outpatient services, or all billable services	Price information is reported to the state	Price information is available to an individual upon request	Price information is available in a publicly available report	Price information is available on a website
Illinois	STATUTE(S): Illinois Compiled Statutes §2215/4-4(a) ENACTED BILL(S): Added: 1984; Amended: H.B. 4580 (2002)	Added: 1984 Amended: 2002	"Hospitals"		"the normal charge incurred"		"any procedure or operation the prospective patient is considering"		"to prospective patients"		
	STATUTE(S): Illinois Compiled Statutes §2215/4-4(b) ENACTED BILL(S): Added: 1984; Amended: H.B. 4580 (2002)	Added: 1984 Amended: 2002	"hospitals"		"the established charges"		"including but not limited to the hospital's private room charge, semi-private room charge, charge for a room with 3 or more beds, intensive care room charges, emergency room charge, operating room charge, electrocardiogram charge, anesthesia charge, chest x-ray charge, blood sugar charge, blood chemistry charge, tissue exam charge, blood typing charge and Rh factor charge"		"to post in letters"		

STATE LAWS ON HEALTH CARE PRICE TRANSPARENCY AND DISCLOSURE											
			SCOPE OF HEALTH CARE PROVIDERS		SCOPE OF PRICE		SCOPE OF SERVICES		LEVEL OF TRANSPARENCY		
STATE	LAWS	YEAR	Scope of Health Care Providers	Insurers are required to report? (Not factored in grading)	Charges	Paid Amount	Scope of Services	Reported to the State	Available upon request	Available in Report	Available on Website
Description	Relevant statute(s) with a hyperlink to the text and all relevant enacted bills with available hyperlinks	If available, date of enactment	May legislate hospitals, surgical centers, or all providers including individual physicians	May legislate health plans, insurers, or carriers to report to the state	Includes average annual charges, charge estimates, actual charges	Demonstrates accepted reimbursement rates from different payers	May legislate only most common procedures, only outpatient services, or all billable services	Price information is reported to the state	Price information is available to an individual upon request	Price information is available in a publicly available report	Price information is available on a website
Indiana	STATUTE(S): Indiana Code §16-21-6 ENACTED BILL(S): Added: S.E.A. 24 (1993); Amended: H.E.A. 1200 (2002), S.E.A. 366 (2011)	Added: 1993 Amended: 2002, 2011	"each hospital"		"Total charge for patient's stay"			"file with the state department"	"shall provide copies of the reports [...] to the public upon request"	"Annually publish a consumer guide to Indiana hospitals"	
Iowa	STATUTE(S): Iowa Code §135.165; §135.166 ENACTED BILL(S): Added: H.B. 2539 (2008); Amended: S.F. 389 (2009)	Added: 2008 Amended: 2009	"hospitals"		"quality and cost measures"		"inpatient, outpatient, and ambulatory information"	"department of public health shall [...] utilize the Iowa hospital association to act as the department's intermediary in collecting, maintaining, and disseminating"			"shall be [...] published on a public internet site available to the general public" (originally the task of a work force now completed and deleted from statute)
Kansas	STATUTE(S): Kansas Statutes §65-6801; §65-6805 ENACTED BILL(S): Added: S.B. 118 (1993); Amended: S.B. 577 (1994), S.B. 272 (2005), S.B. 397 (2012)	Effective 1993 Amended 1994, 2005, 2012	"all providers of health care services and third-party payors"		"costs"			"shall file [...] with the department of health and environment"	"made available in a form [...] to improve the decision-making processes"		

STATE LAWS ON HEALTH CARE PRICE TRANSPARENCY AND DISCLOSURE											
			SCOPE OF HEALTH CARE PROVIDERS		SCOPE OF PRICE		SCOPE OF SERVICES	LEVEL OF TRANSPARENCY			
STATE	LAWS	YEAR	Scope of Health Care Providers	Insurers are required to report? (Not factored in grading)	Charge	Paid Amount	Scope of Services	Reported to the State	Available upon request	Available in Report	Available on Website
Description	Relevant statute(s) with a hyperlink to the text and all relevant enacted bills with available hyperlinks	If available, date of enactment	May legislate hospitals, surgical centers, or all providers including individual physicians	May legislate health plans, insurers, or carriers to report to the state	Includes average annual charges, charge estimates, actual charges	Demonstrates accepted reimbursement rates from different payers	May legislate only most common procedures, only outpatient services, or all billable services	Price information is reported to the state	Price information is available to an individual upon request	Price information is available in a publicly available report	Price information is available on a website
Kentucky	STATUTE(S): Kentucky Revised Statute §216.2929 ENACTED BILL(S): Added: H.B. 250 (1994); Amended: S.B. 343 (1996), H.B. 132 (1998), S.B. 47 (2005), H.B. 44 (2008), H.B. 265 (2012)	Added: 1994 Amended: 1996, 1998, 2005, 2008, 2012	"every hospital and ambulatory facility, differentiated by payor if relevant, and for other provider groups"		"charges [...]include the median charge"			"compiled and reported by the cabinet"		"reported by the cabinet"	"make available on its Web site [...] sufficient explanation to allow consumers to draw meaningful comparisons" AND "provide linkages to organizations that publicly report comparative-charge data for Kentucky providers"
	STATUTE(S): Kentucky Revised Statutes §216.2923, §216.2929 ENACTED BILL(S): Added: H.B. 250 (1994); Amended: S.B. 343 (1996), H.B. 132 (1998), S.B. 47 (2005), H.B. 44 (2008), H.B. 265 (2012)	Added: 1994 Amended: 1996, 1998, 2005, 2008, 2012			"information that relates to the health-care financing and delivery system, information on charges for health-care services"			"the secretary shall [...] collect"			

STATE LAWS ON HEALTH CARE PRICE TRANSPARENCY AND DISCLOSURE											
			SCOPE OF HEALTH CARE PROVIDERS		SCOPE OF PRICE		SCOPE OF SERVICES		LEVEL OF TRANSPARENCY		
STATE	LAWS	YEAR	Scope of Health Care Providers	Insurers are required to report? (Not factored in grading)	Charge	Paid Amount	Scope of Services	Reported to the State	Available upon request	Available in Report	Available on Website
Description	Relevant statute(s) with a hyperlink to the text and all relevant enacted bills with available hyperlinks	If available, date of enactment	May legislate hospitals, surgical centers, or all providers including individual physicians	May legislate health plans, insurers, or carriers to report to the state	Includes average annual charges, charge estimates, actual charges	Demonstrates accepted reimbursement rates from different payers	May legislate only most common procedures, only outpatient services, or all billable services	Price information is reported to the state	Price information is available to an individual upon request	Price information is available in a publicly available report	Price information is available on a website
Louisiana	STATUTE(S): Louisiana Revised Statutes §§40:1300.111, 112, 113, 114 ENACTED BILL(S): Added: H.B. 1462 (1997); Amended: S.B. 287 (2008)	Added: 1997 Amended: 2008	"All health care providers licensed by the state, including but not limited to hospitals, outpatient surgical facilities, and outpatient clinical facilities"		"health care cost, quality, and performance data"			"reported to the Department of Health and Hospitals"			"Internet publication of provider and health plan specific cost, quality, and performance data [...] for access and use by a consumer" AND Unlegislated Louisiana Hospital Inpatient Discharge Database (LAHIDD)
Maine	STATUTE(S): Maine Revised Statutes §§ 8704, 6 ENACTED BILL(S): Added: H.P. 1307 (1996); Amended: S.P. 560 (1997), S.P. 18 (1999), H.P. 1003 (1999), S.P. 395 (2001), H.P. 1187 (2003), H.P. 942 (2005), S.P. 677 (2006), S.P. 290 (2007), H.P. 5 (2007), S.P. 578 (2012)	Added: 1996 Amended: 1997, 1999, 2001, 2003, 2005, 2006, 2007, 2012	"health care facilities, providers or payors"		"clinical, financial, quality and restructuring data"	"clinical, financial, quality and restructuring data"		"board shall develop and implement policies and procedures for the collection, processing, storage and analysis"			

STATE LAWS ON HEALTH CARE PRICE TRANSPARENCY AND DISCLOSURE											
			SCOPE OF HEALTH CARE PROVIDERS		SCOPE OF PRICE		SCOPE OF SERVICES		LEVEL OF TRANSPARENCY		
STATE	LAWS	YEAR	Scope of Health Care Providers	Payers are required to report? (Not factored in grading)	Charge	Paid Amount	Scope of Services	Reported to the State	Available upon request	Available in Report	Available on Website
Description	Relevant statute(s) with a hyperlink to the text and all relevant enacted bills with available hyperlinks	If available, date of enactment	May legislate hospitals, surgical centers, or all providers including individual physicians	May legislate health plans, insurers, or carriers to report to the state	Includes average annual charges, charge estimates, actual charges	Demonstrates accepted reimbursement rates from different payers	May legislate only most common procedures, only outpatient services, or all billable services	Price information is reported to the state	Price information is available to an individual upon request	Price information is available in a publicly available report	Price information is available on a website
Maine	STATUTE(S): Maine Revised Statutes §8712 ENACTED BILL(S): Added: H.P. 1187 (2003); Amended: H.P. 975 (2005), H.P. 85 (2009), S.P. 529 (2009), H.P. 1088 (2010), H.P. 602 (2012)	Added: 2003 Amended: 2005, 2009, 2009, 2010, 2012	"health care facilities and practitioners"			"payments for services rendered"	"services presented must include, but not be limited to, imaging, preventative health, radiology and surgical services and other services that are predominantly elective and may be provided to a large number of patients who do not have health insurance"	"State shall collect, synthesize and publish information"	"shall make reports available to members of the public upon request"		"create a publicly accessible interactive website"
	STATUTE(S): Maine Revised Statutes §8712 ENACTED BILL(S): Added: H.P. 1187 (2003); Amended: H.P. 975 (2005), H.P. 85 (2009), S.P. 529 (2009), H.P. 1088 (2010), H.P. 602 (2012)	Added: 2003 Amended: 2005, 2009, 2009, 2010, 2012		"commercial health insurance companies, 3rd-party administrators and, unless prohibited by federal law, governmental payors"		"prices paid by individual commercial health insurance companies, 3rd-party administrators and, unless prohibited by federal law, governmental payors"	"15 most common diagnosis-related groups and the 15 most common outpatient procedures for all hospitals in the State and the 15 most common procedures for nonhospital health care facilities"	"State shall collect, synthesize and publish information"	"shall make reports available to members of the public upon request"		"create a publicly accessible interactive website"

STATE LAWS ON HEALTH CARE PRICE TRANSPARENCY AND DISCLOSURE											
			SCOPE OF HEALTH CARE PROVIDERS		SCOPE OF PRICE		SCOPE OF SERVICES		LEVEL OF TRANSPARENCY		
STATE	LAWS	YEAR	Scope of Health Care Providers	Insurers are required to report? (Not factored in grading)	Charge	Paid Amount	Scope of services	Reported to the State	Available upon request	Available in Report	Available on Website
Description	Relevant statute(s) with a hyperlink to the text and all relevant enacted bills with available hyperlinks	If available, date of enactment	May legislate hospitals, surgical centers, or all providers including individual physicians	May legislate health plans, insurers, or carriers to report to the state	Includes average annual charges, charge estimates, actual charges	Demonstrates accepted reimbursement rates from different payers	May legislate only most common procedures, only outpatient services, or all billable services	Price information is reported to the state	Price information is available to an individual upon request	Price information is available in a publicly available report	Price information is available on a website
Maine	STATUTE(S): Maine Revised Statutes §8712 ENACTED BILL(S): Added: H.P. 1187 (2003); Amended: H.P. 975 (2005), H.P. 85 (2009), S.P. 529 (2009), H.P. 1088 (2010), H.P. 602 (2012)	Added: 2003 Amended: 2005, 2009, 2009, 2010, 2012	"osteopathic and allopathic physicians in the private office setting"				"the 10 services and procedures most often provided"	"State shall collect, synthesize and publish information"	"shall make reports available to members of the public upon request"		"create a publicly accessible interactive website"
Maryland	STATUTE(S): Maryland Code, Health – General §19-133 ENACTED BILL(S): Added: 1993; Amended: S.B. 221 (1999), H.B. 995 (1999), S.B. 189 (2000), S.B. 196 (2001), S.B. 786 (2001), H.B. 800 (2007)	Added: 1993 Amended: 1994, 1995, 1997, 1999, 2000, 2001, 2007	"health care practitioner or facility"	"payors and governmental agencies"	"the charge for the procedure," [...]"health care costs, utilization, or resources"			"the Commission shall [collect]"		"shall publish an annual report [...] Describ[ing] the variation in fees charged by health care practitioners and facilities"	
	STATUTE(S): Maryland Code, Health – General §§ 19-202, 7 ENACTED BILL(S): Added: 1982; Amended: 1984, 1997, 1999, S.B. 479 (2003), S.B. 380 (2006), H.B. 844 (2007)	Added: 1982 Amended: 1984, 1997, 1999, 2003, 2006, 2007			"Health care costs"			Creates the "Health Services Cost Review Commission [that] shall Periodically participate in or do analyses and studies of"		"Each report filed and each summary, compilation, and report required under this subtitle available for public inspection"	

STATE LAWS ON HEALTH CARE PRICE TRANSPARENCY AND DISCLOSURE											
			SCOPE OF HEALTH CARE PROVIDERS		SCOPE OF PRICE		SCOPE OF SERVICES		LEVEL OF TRANSPARENCY		
STATE	LAWS	YEAR	Scope of Health Care Providers	Insurers are required to report? (Not factored in grading)	Charge	Paid Amount	Scope of Services	Reported to the State	Available upon request	Available in Report	Available on Website
Description	Relevant statute(s) with a hyperlink to the text and all relevant enacted bills with available hyperlinks	If available, date of enactment	May legislate hospitals, surgical centers, or all providers including individual physicians	May legislate health plans, insurers, or carriers to report to the state	Includes average annual charges, charge estimates, actual charges	Demonstrates accepted reimbursement rates from different payers	May legislate only most common procedures, only outpatient services, or all billable services	Price information is reported to the state	Price information is available to an individual upon request	Price information is available in a publicly available report	Price information is available on a website
Massachusetts	STATUTE(S): Massachusetts General Laws 12C §8 (a) ENACTED BILL(S): Added: S.B. 2400 (2012)	Added: 2012	"institutional providers and their parent organizations and any other affiliated entities, non-institutional providers and provider organizations"		"revenues, charges, costs, prices, and utilization [...]filing of a charge book, the filing of cost data and audited financial statements and the submission of merged billing and discharge data"		"medical, surgical, diagnostic and ancillary services"	"The center shall also collect and analyze"			
	STATUTE(S): Massachusetts General Laws 12C §8 (b) ENACTED BILL(S): Added: S.B. 2400 (2012)	Added: 2012	"any acute or non-acute hospital"		"a charge book, the filing of cost data and audited financial statements and the submission of merged billing and discharge data"					"at least annually, publish a report analyzing the comparative information to assist third-party payers and other purchasers of health services in making informed decisions"	"shall publicly report and place on its website [...] relative prices and hospital inpatient and outpatient costs, including direct and indirect costs"
	STATUTE(S): Massachusetts General Laws 12C §8 (d) ENACTED BILL(S): Added: S.B. 2400 (2012)	Added: 2012			"relative prices"		"inpatient and outpatient"				"shall publicly report and place on its website"

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			SCOPE OF HEALTH CARE PROVIDERS		SCOPE OF PRICE		SCOPE OF SERVICES		LEVEL OF TRANSPARENCY		
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Massachusetts	STATUTE(S): Massachusetts General Laws 12C §10 ENACTED BILL(S): Added: S.B. 2400 (2012)	Added: 2012		"from private and public health care payers, including third-party administrators"	"relative prices for the payer's participating health care providers by provider type which shows the average relative price, the extent of variation in price, stated as a percentage, and identifies providers who are paid more than 10 per cent, 15 per cent and 20 per cent above and more than 10 per cent, 15 per cent and 20 per cent below the average relative price"	"submit claims data [...] and relative prices paid to every hospital, registered provider organization, physician group, ambulatory surgical center, freestanding imaging center, mental health facility, rehabilitation facility, skilled nursing facility and home health provider in the payer's network, by type of provider, with hospital inpatient and outpatient prices listed separately by [insurance] product type"		"The center shall require the submission of data and other information"		"Except as specifically provided otherwise by the center or under this chapter, insurer data collected by the center under this section shall not be a public record"	
	STATUTE(S): Massachusetts General Laws 12C §16 ENACTED BILL(S): Added: S.B. 2400 (2012)	Added: 2012	"health care provider, provider organization"	"private and public health care payer"	"costs and cost trends [...] price [and] price variation between health care providers, by payer and provider type"	"costs and cost trends [...] and price variation between health care providers, by payer and provider type"		"The center collects"		"The center shall publish an annual report"	

STATE LAWS ON HEALTH CARE PRICE TRANSPARENCY AND DISCLOSURE											
			SCOPE OF HEALTH CARE PROVIDERS		SCOPE OF PRICE		SCOPE OF SERVICES		LEVEL OF TRANSPARENCY		
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Massachusetts	STATUTE(S): Massachusetts General Laws 6A C §16K ENACTED BILL(S): Added: H.B. 4479 (2006) Amended: H.B. 5240 (2006), S.B. 2863 (2008), S.B. 2585 (2010), S.B. 2400 (2012)	Added: 2006 Amended: 2006, 2008, 2010, 2012		"health care quality and cost data"		"Cost information shall include, at a minimum, the average payment [...] on behalf of insured patients"	"for obstetrical services, physician office visits, high-volume elective surgical procedures, high-volume diagnostic tests and high-volume therapeutic procedures"	"shall be collected"			"shall establish and maintain a consumer health information website [...] comparing the cost and quality of health care services [...] by facility and, as applicable, by clinician or physician group practice"
	STATUTE(S): Massachusetts General Laws 111C § 228 ENACTED BILL(S): Added: S.B. 2400 (2012)	Added: 2012	"a health care provider"		"disclose the [...] charge"	"disclose the [...] the contractually agreed upon amount paid by a carrier to a health care provider for health care services provided to an insured" AND "out-of-pocket costs"	"of the admission, procedure or service, including the amount for any facility fees required"		"upon request by a patient or prospective patient"		

STATE LAWS ON HEALTH CARE PRICE TRANSPARENCY AND DISCLOSURE											
			SCOPE OF HEALTH CARE PROVIDERS		SCOPE OF PRICE		SCOPE OF SERVICES		LEVEL OF TRANSPARENCY		
STATE	LAWS	YEAR	Scope of Health Care Providers	Insurers are required to report? (Not factored in grading)	Charge	Paid Amount	Scope of Services	Reported to the State	Available upon request	Available in Report	Available on Website
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Minnesota	STATUTE(S): Minnesota Statutes §62J.82 ENACTED BILL(S): Added: H.F. 139 (2005) Amended: H.F. 1078 (2007)	Added: 2005 Amended: 2007	"hospital"		"Charge information, [including] average charge, average charge per day and median charge"		"for each of the 50 most common inpatient diagnosis-related groups and the 25 most common outpatient surgical procedures"				"The Minnesota Hospital Association shall develop a Web-based system"
	STATUTE(S): Minnesota Statutes §62J.052 ENACTED BILL(S): Added: S.F. 1204 (2005) Amended: S.F. 3480 (2006)	Added: 2005 Amended: 2006	"Each pharmacy"		"usual and customary price for a prescription drug"				"readily available at no cost to the patient"		
	STATUTE(S): Minnesota Statutes §62U.04 (Subd. 1) ENACTED BILL(S): Added: S.F. 3780 (2008) Amended: S.F. 2082 (2009), H.F. 3056 (2010), H.F. 25 (2011), S.F. 1809 (2012)	Added: 2008 Amended: 2009, 2010, 2011, 201	"providers"		"comparative information to consumers on variation"						
	STATUTE(S): Minnesota Statutes §62U.04 (Subd. 3c) ENACTED BILL(S): Added: S.F. 3780 (2008) Amended: S.F. 2082 (2009), H.F. 3056 (2010), H.F. 25 (2011), S.F. 1809 (2012)	Added: 2008 Amended: 2009, 2010, 2011, 2012	"providers"		"total cost" AND "condition-specific cost"					"public report"	

STATE LAWS ON HEALTH CARE PRICE TRANSPARENCY AND DISCLOSURE											
			SCOPE OF HEALTH CARE PROVIDERS		SCOPE OF PRICE		SCOPE OF SERVICES		LEVEL OF TRANSPARENCY		
			Scope of Health Care Providers	Insurers are required to report? (Not factored in grading)	Charge	Paid Amount	Scope of Services	Reported to the State	Available upon request	Available in Report	Available on Website
STATE	LAWS	YEAR									
Description	Relevant statute(s) with a hyperlink to the text and all relevant enacted bills with available hyperlinks	If available, date of enactment	May legislate hospitals, surgical centers, or all providers including individual physicians	May legislate health plans, insurers, or carriers to report to the state	Includes average annual charges, charge estimates, actual charges	Demonstrates accepted reimbursement rates from different payers	May legislate only most common procedures, only outpatient services, or all billable services	Price information is reported to the state	Price information is available to an individual upon request	Price information is available in a publicly available report	Price information is available on a website
Minnesota	STATUTE(S): Minnesota Statutes §62U.04 (Subd. 5) ENACTED BILL(S): Added: S.F. 3780 (2008) Amended: S.F. 2082 (2009), H.F. 3056 (2010), H.F. 25 (2011), S.F. 1809 (2012)	Added: 2008 Amended: 2009, 2010, 2011, 2012		"all health plan companies and third-party administrators"		"submit data on their contracted prices with health care providers"		"to a private entity designated by the commissioner of health"			
	STATUTE(S): Minnesota Statutes §621.82 ENACTED BILL(S): Added: H.F. 139 (2005) Amended: H.F. 1078 (2007)	Added: 2005 Amended: 2007	"hospital"		"Charge information, [including] average charge, average charge per day and median charge"		"for each of the 50 most common inpatient diagnosis-related groups and the 25 most common outpatient surgical procedures"				"The Minnesota Hospital Association shall develop a Web-based system"
	STATUTE(S): Minnesota Statutes §144.698 ENACTED BILL(S): Added: S.F. 60 (1976) Amended: S.F. 109 (1977), H.F. 1966 (1984), H.F. 1759 (1989), S.F. 910 (1991), S.F. 2080 (2004), H.F. 1078 (2007)	Added: 1976 Amended: 1977, 1984, 1989, 1991, 2004, 2007	"Each hospital and each outpatient surgical center"		"cost information"			"shall file annually with the commissioner of health"		"All reports [...] shall be open to public inspection"	
	STATUTE(S): Minnesota Statutes § 144.699 ENACTED BILL(S): Added: S.F. 60 (1976) Amended: S.F. 109 (1977), H.F. 1966 (1984), S.F. 51 (1987), H.F. 1078 (2007)	Added: 1976 Amended: 1977, 1984, 1987, 2007	"hospitals, outpatient surgical centers, home care providers, and professionals"				"for procedures and services that are representative of the diagnoses and conditions for which citizens of this state seek treatment"			"The Commissioner of Health shall "disseminate available price information" AND "encourage [providers] to publish prices"	

STATE LAWS ON HEALTH CARE PRICE TRANSPARENCY AND DISCLOSURE											
			SCOPE OF HEALTH CARE PROVIDERS		SCOPE OF PRICE		SCOPE OF SERVICES		LEVEL OF TRANSPARENCY		
STATE	LAWS	YEAR	Scope of Health Care Providers	Insurers are required to report? (not factored in grading)	Charge	Paid Amount	Scope of Services	Reported to the State	Available upon request	Available in Report	Available on Website
Description	Relevant statute(s) with a hyperlink to the text and all relevant enacted bills with available hyperlinks	If available, date of enactment	May legislate hospitals, surgical centers, or all providers including individual physicians	May legislate health plans, insurers, or carriers to report to the state	Includes average annual charges, charge estimates, actual charges	Demonstrates accepted reimbursement rates from different payers	May legislate only most common procedures, only outpatient services, or all billable services	Price information is reported to the state	Price information is available to an individual upon request	Price information is available in a publicly available report	Price information is available on a website
Minnesota	STATUTE(S): Minnesota Statutes § 144.701 ENACTED BILL(S): Added: S.F. 60 (1976) Amended: S.F. 109 (1977), H.F. 2175 (1982), H.F. 1966 (1984), H.F. 1759 (1989), S.F. 3346 (1998), H.F. 2446 (2004), S.F. 2082 (2009)	Added: 1976 Amended: 1977, 1982, 1984, 1989, 2998, 4004, 2009	"each hospital and outpatient surgical center"		"a current rate schedule"			"shall be filed with the commissioner of health"			
	STATUTE(S): Minnesota Statutes §144.0506 ENACTED BILL(S): S.F. 367 (2006)	Added: 2006	"health care provider"		"charges"		"for common procedures"				"agency Web sites, including minnesota-healthinfo.com"
Missouri	STATUTE(S): Missouri Revised Statutes §192.665, §192.667 ENACTED BILL(S): Added: H.B. 1574 (1992) Amended: S.B. 721 (1992), S.B. 796 (1992), S.B. 1279 (2004)	Added: 1992 Amended: 1992, 2004	"All health care providers [includes hospitals and ambulatory surgical centers]"		"charge data"			"provide to the department"		"The report shall be made available to the public for a reasonable charge" AND "The Hospital Industry Data Institute shall publish a report" AND "publish information including at least an annual consumer guide"	

STATE LAWS ON HEALTH CARE PRICE TRANSPARENCY AND DISCLOSURE											
			SCOPE OF HEALTH CARE PROVIDERS		SCOPE OF PRICE		SCOPE OF SERVICES		LEVEL OF TRANSPARENCY		
STATE	LAWS	YEAR	Scope of Health Care Providers	Insurers are required to report? (Not factored in grading)	Charge	Paid Amount	Scope of Service	Reported to the State	Available upon request	Available in Report	Available on Website
Description	Relevant statute(s) with a hyperlink to the text and all relevant enacted bills with available hyperlinks	If available, date of enactment	May legislate hospitals, surgical centers, or all providers including individual physicians	May legislate health plans, insurers, or carriers to report to the state	Includes average annual charges, charge estimates, actual charges	Demonstrates accepted reimbursement rates from different payers	May legislate only most common procedures, only outpatient services, or all billable services	Price information is reported to the state	Price information is available to an individual upon request	Price information is available in a publicly available report	Price information is available on a website
Montana	UNLEGISLATED		"facility specific information"		"charges"		"inpatient and outpatient"				Unlegislated Montana PricePoint developed by Montana Hospital Association and An Association of Montana Health Care Providers
Nebraska	STATUTE(S): Nebraska Statutes §71-2075 ENACTED BILL(S): Added: 1985; Amended: L.B. 1210 (1994)	Added: 1985 Amended: 1994	"each hospital [...] and ambulatory surgical centers"		"average charges"				"Upon the written request of a prospective patient" AND "shall provide notice to the public that such hospital or center will provide an estimate of charges"		
Nevada	STATUTE(S): Nevada Revised Statutes §§ 439A.220, 439A.240, 439A.260, 439A.270 ENACTED BILL(S): Added: A.B. 146 (2007); Amended: S.B. 319 (2009), A.B. 160 (2011), S.B. 264 (2011), S.B. 338 (2011), S.B. 340 (2011)	Added: 2007 Amended: 2009, 2011	"each hospital" AND "each surgical center for ambulatory patients"		"average billed charges" AND "charges imposed"		"reported by diagnosis-related groups for inpatients and for the 50 medical treatments for outpatients" AND "for [...] potentially preventable readmissions"	"The Department shall establish and maintain a program that [...] must include the collection	"Upon request, make the information that is contained on the Internet website available in printed form"	"shall make a summary of the information available to Consumers of health care (and) the general public"	"shall establish and maintain an Internet website"

STATE LAWS ON HEALTH CARE PRICE TRANSPARENCY AND DISCLOSURE											
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STATE	LAWS	YEAR	Scope of Health Care Providers	Insurers are required to report? (Not factored in grading)	Charges	Paid Amount	Scope of Services	Reported to the State	Available upon request	Available in Report	Available on Website
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Nevada	STATUTE(S): Nevada Revised Statutes §449.490 ENACTED BILL(S): Added: 1975; Amended: 1985, 1987, A.B. 342 (2005), A.B. 146 (2007), A.B. 160 (2011)	Added: 1975 Amended: 1985, 1987, 2005, 2007, 2011	"each hospital"		"chargemaster"			"made available to the Department"	"information that may relate to individual citizens may be released"		
New Hampshire	STATUTE(S): New Hampshire Revised Statutes §§420-G:11, 420-G:11-a ENACTED BILL(S): Added: H.B. 670 (2003) Amended: S.B. 74 (2005)	Added: 2003 Amended: 2005		"All health carriers"	"encrypted claims data [and] Health Employer Data and Information Set (HEDIS) data	"encrypted claims data [and] Health Employer Data and Information Set (HEDIS) data		"to the department"			"develop a comprehensive health care information system" (NHCHIS) AND "shall be available as a resource for insurers, employers, providers, purchasers of health care, [...] to enhance the ability of New Hampshire consumers and employers to make informed and cost-effective health care choices"
	STATUTE(S): New Hampshire Revised Statutes §126:25 ENACTED BILL(S): Added: 1985 Amended: S.B. 197 (2009), H.B. 544 (2009), H.B. 629 (2011)	Effective: 1985 Amended: 2009, 2011	"Acute care hospitals, specialty hospitals, nursing homes"		"charge by discharge data [...] average patient day charge data"			"shall file health care data as required by the commissioner"			

STATE LAWS ON HEALTH CARE PRICE TRANSPARENCY AND DISCLOSURE											
			SCOPE OF HEALTH CARE PROVIDERS		SCOPE OF PRICE		SCOPE OF SERVICES	LEVEL OF TRANSPARENCY			
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New Jersey	STATUTE(S): New Jersey Statutes §26:2H-5, §26:2H-18.55 ENACTED BILL(S): Added: 1971 and Assembly 2100 (1992); Amended: Assembly 2616 (1995), Assembly 1532 (1996), Senate 1181 (1998), Senate 539 (2006), Senate 1796 (2008)	Added: 1971, 1992 Amended: 1995, 1996, 1998, 2008	"hospital"	"costs" AND "charges for health care services"	"schedules of rates, payments, reimbursement"			"Reported to the department" AND "use of centralized data storage and transmission technology"		"reports to provide assistance to consumers of health care in this State in making prudent health care choices"	Unlegislated website
New Mexico	STATUTE(S): New Mexico Statutes §§ 24-14A-3, 24-14A-34, 24-14A-37 ENACTED BILL(S): Added: 1989; Amended: S.B. 556 (1994), H.B. 1008 (2005), S.B. 786 (2005), H.B. 293 (2009), H.B. 18 (2012)	Added: 1989 Amended: 1994, 2005, 2012	"all data sources"		"collect health data sufficient for consumers to be able to evaluate health care services, plans, providers and payers and to make informed decisions regarding quality, cost and outcome of care across the spectrum of health care services, providers and payers"			"serve as a health information clearinghouse, including facilitating private and public collaborative, coordinated data collection"	"Any person may obtain any aggregate data"	"a report in printed format that provides information of use to the general public shall be produced annually"	
New York	STATUTE(S): New York Public Health Law §2816 ENACTED BILL(S): Added: A. 1644 (2001), Amended: A. 4122–C (2005), S. 2809-D (2011), S. 2812-C (2011)	Added: 2001 Amended: 2005, 2011	"hospitals [and] all ambulatory facilities" AND "emergency departments" AND "outpatient clinic[s]"		"patient and other data element"		"Top 50 diagnostic categories" AND "Top 50 surgical procedures"			"the publication and release of data reported" (SPARCS)	

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North Carolina	STATUTE(S): North Carolina General Statutes §131E-214.4 ENACTED BILL(S): Added: S.B. 345 (1995); Amended: S.B. 352 (1997)	Added: 1995 Amended: 1997			"charges"		"35 most frequently reported charges"	"The center shall require the submission of data and other information"	"makes medical care data available to interested persons, including medical care providers, third party payors, medical care consumers, and health care planners [...] compile reports from the patient data and make the reports available upon request to interested persons at a reasonable charge"		
North Dakota	STATUTE(S): North Dakota Century Code §§23-01.1-02.1 ENACTED BILL(S): Added: S.B. 2589 (1991)	Added: 1991	"each licensed physician practicing medicine"	"insurers, nonprofit health service corporations, health maintenance organizations, and state agencies"	"average fees charged"			"health care data committee shall create a data collection"		"shall prepare a report which must [...] for consumers to use in comparing"	

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North Dakota	STATUTE(S): North Dakota Century Code §§23-01.1-02 ENACTED BILL(S): Added: S.B. 2589 (1991); Amended: H.B. 1058 (1995), H.B. 1065 (2003)	Added: 1991 Amended: 1995, 2003	"each nonfederal acute care hospital in this state""		"average aggregate charges by diagnosis [...] and the average charges by source of payment"		"twenty-five most common diagnoses"	"the health care data committee may collect, store, analyze, and provide"		"Prepare an annual report comparing the cost of hospitalization by diagnosis [...] Establish procedures that assure public availability of the information required to make informed health care purchasing decisions"	
Ohio	STATUTE(S): Ohio Revised Code §3727.42 ENACTED BILL(S): Added: H.B. 197 (2006); Amended: H.B. 487 (2012)	Added: 2006 Amended: 2012	"Every hospital"		"a price information list [...] including (1) The usual and customary room and board charges; (2) Rates charged for nursing care, if the hospital charges separately for nursing care [...] (3) The usual and customary charges, stated separately for inpatients and outpatients if different charges are imposed"		"Room and board [...] selected number of x-ray, laboratory, emergency room, operating room, delivery room, physical therapy, occupational therapy and respiratory therapy services"		"available for inspection by the public" AND "At the time of admission, or as soon as practical thereafter, inform each patient of the availability of the list and on request provide the patient with a free copy of the list" AND "On request, provide a paper copy of the list to any person"		"Make the list available free of charge on the hospital's internet web site" AND Hospital Association's site

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STATE	LAWS	YEAR	Scope of Health Care Providers	Insurers are required to report? (Not factored in grading)	Charge	Paid Amount	Scope of Services	Reported to the State	Available upon request	Available in Report	Available on Website
Description	Relevant statute(s) with a hyperlink to the text and all relevant enacted bills with available hyperlinks	If available, date of enactment	May legislate hospitals, surgical centers, or all providers including individual physicians	May legislate health plans, insurers, or carriers to report to the state	Includes average annual charges, charge estimates, actual charges	Demonstrates accepted reimbursement rates from different payers	May legislate only most common procedures, only outpatient services, or all billable services	Price information is reported to the state	Price information is available to an individual upon request	Price information is available in a publicly available report	Price information is available on a website
Ohio	STATUTE(S): Ohio Revised Code §3727.34, §3727.39 ENACTED BILL(S): Added: H.B. 197 (2006)	Added: 2006	"each hospital"		"The mean, median, and range of total hospital charges"		"pertaining to inpatient services [...] of the sixty diagnosis related groups [...]most frequently treated" AND "pertaining to outpatient services [...] of the sixty categories [...] most frequently provided"	"submit to the director of health"	"On request, the hospital shall make copies available"		"available on an internet web site"
Oklahoma	STATUTE(S): Oklahoma Statutes §1-119; §1- 121 ENACTED BILL(S): Added: H.B. 2379 (1992); Amended: H.B. 1573 (1993), H.B. 2570 (1994), H.B. 2501 (1996), H.B. 2868 (1998), S.B. 1585 (2000)	Added: 1992 Amended 1993, 1994, 1996, 1998, 2000	"information providers"		"reimburse-ment, costs of operation, [...] rates, charges"			"To the Division of Health Care Information within the State Department of Health"			
Oregon	ENACTED BILL(S): Added: S.B. 329 (2007)	Added: 2007	"medical and dental providers"	"health plans"	AND "informa-tion about the cost"			"to the department"		"provides enrollees"	

STATE LAWS ON HEALTH CARE PRICE TRANSPARENCY AND DISCLOSURE											
			SCOPE OF HEALTH CARE PROVIDERS		SCOPE OF PRICE		SCOPE OF SERVICES		LEVEL OF TRANSPARENCY		
STATE	LAWS	YEAR	Scope of Health Care Providers	Insurers are required to report? (Not factored in grading)	Charges	Paid Amount	Scope of Services	Reported to the State	Available upon request	Available in Report	Available on Website
Description	Relevant statute(s) with a hyperlink to the text and all relevant enacted bills with available hyperlinks	If available, date of enactment	May legislate hospitals, surgical centers, or all providers including individual physicians	May legislate health plans, insurers, or carriers to report to the state	Includes average annual charges, charge estimates, actual charges	Demonstrates accepted reimbursement rates from different payers	May legislate only most common procedures, only outpatient services, or all billable services	Price information is reported to the state	Price information is available to an individual upon request	Price information is available in a publicly available report	Price information is available on a website
Oregon	STATUTE(S): Oregon Revised Statutes §442.405; §442.430; §442.460 ENACTED BILL(S): Added: 1985, Amended: S.B. 1079 (1995), H.B. 2894 (1997), H.B. 2146 (1999)	Added: 1985 Amended 1995, 1997, 1999	"health care facilities"	"insurers or other third-party payers or employers or other purchasers of health care"	"costs of health care" AND "advance disclosure of the estimated out-of-pocket costs of a service or procedure"			"Requires the office to conduct or cause to have conducted such analyses and studies"		"file for public disclosure reports that will enable both private and public purchasers of services from such facilities to make informed decisions"	Unlegislated website
Pennsylvania	STATUTE(S): Pennsylvania Unconsolidated Statutes §449.6 ENACTED BILL(S): Added: 1986; Amended: S.B. 1052 (1993), S.B. 387 (2003), S.B. 89 (2009)	Added: 1986 Amended: 1993, 2003, 2009	"Hospitals, ambulatory services facilities, and physicians."		"Total charges" AND "charges"	"actual payments to each physician or professional rendering service"	"including, but not limited to, room and board, radiology, laboratory, operating room, drugs, medical supplies and other goods and services" AND "of each physician or professional rendering service relating to an incident of hospitalization or treatment in an ambulatory service facility"	"the council shall be required to collect"		"Make available and provide comparisons"	
	STATUTE(S): Pennsylvania Unconsolidated Statutes §449.7 ENACTED BILL(S): Added: 1986; Amended: S.B. 1052 (1993), S.B. 387 (2003), S.B. 89 (2009)	Added: 1986 Amended: 1993, 2003, 2009	"for every provider of both inpatient and outpatient services"		"cost"	"payment"				"prepare and issue reports"	

STATE LAWS ON HEALTH CARE PRICE TRANSPARENCY AND DISCLOSURE											
			SCOPE OF HEALTH CARE PROVIDERS		SCOPE OF PRICE		SCOPE OF SERVICES		LEVEL OF TRANSPARENCY		
			Scope of Health Care Providers	Insurers are required to report? (Not factored in grading)	Charge	Paid Amount	Scope of Services	Reported to the State	Available upon Request	Available in Report	Available on Website
STATE	LAWS	YEAR									
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Rhode Island	STATUTE(S): Rhode Island General Laws §§23-17.17-10 ENACTED BILL(S): Added: 1956; Amended: S 2481B (2008), H 7465A (2008)	Added: 1956 Amended: 2008	"health care providers, health care facilities"	"insurers and governmental agencies"	"health care costs, prices"	"health insurance claims"	"health care facility services"	"The director shall establish and maintain a unified health care quality and value database"		"Provide information to consumers and purchasers of health care"	
South Carolina	STATUTE(S): South Carolina Code §44-6-170 ENACTED BILL(S): Added: 1985; Amended: 1989, S.B. 474 (1991), S.B. 507 (1993), H.B. 3546 (1993), S.B. 691 (1995)	Added: 1985 Amended: 1993, 1995	"All general acute care hospitals and specialized hospitals including, but not limited to, psychiatric hospitals, alcohol and substance abuse hospitals, and rehabilitation hospitals"	"or insurer"	"financial information" AND "charges"		"of inpatient and outpatient information"	"reported to the office"		"appropriate dissemination of health care-related data reports"	
South Dakota	STATUTE(S): South Dakota Codified Laws §34-12E-8 ENACTED BILL(S): Added: H.B. 1384 (1994)	Added: 1994	"health care provider or facility"		"All fees and charges"				"Upon request of patient"		
	STATUTE(S): South Dakota Codified Laws §§34-12E-11, 11.1 ENACTED BILL(S): Added: S.B. 169 (2005), SB 182 (2008)	Added: 2005, 2008	"Any hospital"		"the charge information"		"All Patient Refined Diagnosis-Related Groups for which that hospital had at least ten cases"	"shall report annually to the South Dakota Association of Health Care Organizations"			"develop a web-based system, available to the public at no cost, for reporting the charge information of hospitals"

STATE LAWS ON HEALTH CARE PRICE TRANSPARENCY AND DISCLOSURE											
			SCOPE OF HEALTH CARE PROVIDERS		SCOPE OF PRICE		SCOPE OF SERVICES		LEVEL OF TRANSPARENCY		
STATE	LAWS	YEAR	Scope of Health Care Providers	Insurers are required to report? (Not factored in grading)	Charge	Paid Amount	Scope of Services	Reported to the State	Available upon request	Available in Report	Available on Website
Description	Relevant statute(s) with a hyperlink to the text and all relevant enacted bills with available hyperlinks	If available, date of enactment	May legislate hospitals, surgical centers, or all providers including individual physicians	May legislate health plans, insurers, or carriers to report to the state	Includes average annual charges, charge estimates, actual charges	Demonstrates accepted reimbursement rates from different payers	May legislate only most common procedures, only outpatient services, or all billable services	Price information is reported to the state	Price information is available to an individual upon request	Price information is available in a publicly available report	Price information is available on a website
Tennessee	STATUTE(S): Tennessee Code §68-1-108, §68- 1- 119 ENACTED BILL(S): Added: 1985, S.B. 2407 (2002); Amended: S.B. 63 (1994), H.B. 3449 (2004), H.B. 2827 (2006), H.B. 596 (2011), S.B. 3011 (2012), S.B. 2416 (2012)	Added: 1985, 2002 Amended: 1994, 2004, 2006, 2011, 2012	"Each licensed hospital" AND "Each licensed ambulatory surgical treatment center (ASTC) and each licensed outpatient diagnostic center (ODC)"		"all claims data"		"on every inpatient and outpatient discharge"	"to the commissioner of health [who] shall promptly make the data available for review and copying by the Tennessee hospital association (THA)"		"shall prescribe conditions under which the processed and verified data are available to the public"	
Texas	STATUTE(S): Vernon's Texas Statute and Codes Texas Health & Safety Code §§108.006, 9, 11, 12 ENACTED BILL(S): Added: H.B. 1048 (1995); Amended: S.B. 802 (1997), H.B. 1513 (1999), S.B. 872 (2005)	Added: 1994 Amended: 1997, 1999, 2005	"hospitals, ambulatory surgical centers, and free-standing radiology centers"		"collect health care charges"		"prioritize data collection efforts on inpatient and outpatient surgical and radiological procedures"	"The council shall develop a statewide health care data collection system to"	"provide public use data and data collected [...] to those requesting it"	"make reports to the legislature, the governor, and the public on the charges and rate of change in the charges for health care services"	"shall provide a means for computer-to-computer access" AND Unlegislated Texas Pricepoint
	STATUTE(S): Vernon's Texas Statute and Codes Health & Safety Code § 324.051 AND Occupations Code § 154.002 ENACTED BILL(S): Added: S.B. 1731 (2007) Amended: H.B. 2256 (2009)	Added: 2007 Amended: 2009	"the facility" AND "physician"		"information in the guide concerning facility pricing practices and the correlation between a facility's average charge" AND "the actual, billed charge"		"an inpatient admission or outpatient surgical procedure"	"to submit to the Department"		"shall make available on the department's internet website a consumer guide to health care"	

STATE LAWS ON HEALTH CARE PRICE TRANSPARENCY AND DISCLOSURE											
			SCOPE OF HEALTH CARE PROVIDERS		SCOPE OF PRICE		SCOPE OF SERVICES		LEVEL OF TRANSPARENCY		
STATE	LAWS	YEAR	Scope of Health Care Providers	Insurers are required to report? (Not factored in grading)	Charge	Paid Amount	Scope of Services	Reported to the State	Available upon request	Available in Report	Available on Website
Description	Relevant statute(s) with a hyperlink to the text and all relevant enacted bills with available hyperlinks	If available, date of enactment	May legislate hospitals, surgical centers, or all providers including individual physicians	May legislate health plans, insurers, or carriers to report to the state	Includes average annual charges, charge estimates, actual charges	Demonstrates accepted reimbursement rates from different payers	May legislate only most common procedures, only outpatient services, or all billable services	Price information is reported to the state	Price information is available to an individual upon request	Price information is available in a publicly available report	Price information is available on a website
Texas	STATUTE(S): Vernon's Texas Statute and Codes Health & Safety Code §324.101 AND Occupations Code §101.352 ENACTED BILL(S): Added: S.B. 1731 (2007); Amended: H.B. 2256 (2009)	Added: 2007 Amended: 2009	"Facility" and "physician"		"an estimate of the facility's [or physician's] charges"		"for any elective inpatient admission or nonemergency outpatient surgical procedure or other service"		"on request and before the scheduling of the admission or procedure or service"		
Utah	STATUTE(S): Utah Health Code §§26-33a-104, 106.1, 106.5 ENACTED BILL(S): Added: S.B. 235 (1990), S.B. 171 (1996), H.B. 9 (2007); Amended: S.B. 171 (1996), H.B. 208 (2001), S.B. 132 (2005), H.B. 9 (2007), H.B. 63 (2008), H.B. 294 (2010), H.B. 213 (2011), H.B. 144 (2012)	Added: 1990, 1996, 2007 Amended: 1996, 2001, 2005, 2007, 2008, 2010, 2011, 2012	"health care providers"		"measurements of cost" AND "rate and price increases"			"purpose of the committee is to direct a statewide effort to collect, analyze, and distribute health care data"		"assist the Legislature and the public with awareness of, and the promotion of, transparency in the health care market by reporting"	
	STATUTE(S): Utah Health Code §§26-3-2, 4 ENACTED BILL(S): Added: 1981	Added: 1981			"health care costs and financing"			the department may [...] collect and maintain health data		"publish, make available, and disseminate such statistics on as wide a basis as practicable"	

STATE LAWS ON HEALTH CARE PRICE TRANSPARENCY AND DISCLOSURE											
			SCOPE OF HEALTH CARE PROVIDERS		SCOPE OF PRICE		SCOPE OF SERVICES		LEVEL OF TRANSPARENCY		
STATE	LAWS	YEAR	Scope of Health Care Providers	Insurers are required to report? (Not factored in grading)	Charge	Paid Amount	Scope of Services	Reported to the State	Available upon request	Available in Report	Available on Website
Description	Relevant statute(s) with a hyperlink to the text and all relevant enacted bills with available hyperlinks	If available, date of enactment	May legislate hospitals, surgical centers, or all providers including individual physicians	May legislate health plans, insurers, or carriers to report to the state	Includes average annual charges, charge estimates, actual charges	Demonstrates accepted reimbursement rates from different payers	May legislate only most common procedures, only outpatient services, or all billable services	Price information is reported to the state	Price information is available to an individual upon request	Price information is available in a publicly available report	Price information is available on a website
Utah	STATUTE(S): Utah Health Code §26-21-27 ENACTED BILL(S): H.B. 294 (2010)	Added: 2010	"a health care facility"		"a list of prices charged"		"in-patient procedures; (b) out-patient procedures; (c) the 50 most commonly prescribed drugs in the facility; (d) imaging services; and (e) implants"	submitted to "the department"			"available for the consumer" Utah Pricepoint
Vermont	STATUTE(S): Vermont Statutes 18 §9405b ENACTED BILL(S): Added: H. 128 (2003) Amended: H. 516 (2005), H. 227 (2006), H. 881 (2006), H. 380 (2007), H. 202 (2011)	Added: 2003 Amended: 2005, 2006, 2007, 2011	"hospitals and other groups of health care professionals"		"measures that provide valid, reliable, useful, and efficient information for payers and the public for the comparison of charges"		"for higher volume health care services"	"The commissioner[...] shall [establish] a standard format for community reports"		"The commissioner shall publish the reports on a public website and shall develop and include a format for comparisons of hospitals within the same categories of quality and financial indicators"	
	STATUTE(S): Vermont Statutes 18 §9410 ENACTED BILL(S): Added: H.B. 733 (1992), Amended: S. 345 (1996), H. 516 (2005), H. 678 (2006), H. 861 (2006), H. 229 (2007), S. 115 (2007), S. 42 (2009), H. 444 (2009), H. 202 (2011)	Added: 1992 Amended: 1996, 2005, 2006, 2007, 2009, 2010, 2011	"health care providers, health care facilities"	"All health insurers"	"any other information relating to health care costs, prices"	"health insurance claim"		"required to be filed by the commissioner"			"a consumer health care price and quality information system designed to make available to consumers transparent health care price information"

STATE	LAWS	YEAR	STATE LAWS ON HEALTH CARE PRICE TRANSPARENCY AND DISCLOSURE												
			SCOPE OF HEALTH CARE PROVIDERS		SCOPE OF PRICE			SCOPE OF SERVICES		LEVEL OF TRANSPARENCY					
			Scope of Health Care Providers	Insurers are required to report (that included in grading)	Charge	Paid Amounts	Demonstrates accepted reimbursement rates from different payers	Scope of Services	Price information is reported to the state	Reported to Insurers	Available upon request	Available in Report	Available on Website	Price information is available on a website
Description	Relevant statute(s) with a hyperlink to the text and all relevant enacted bills with available hyperlinks	If available, date of enactment	May legislate hospitals, surgical centers, or all providers including individual physicians	May legislate health plans, insurers, or carriers to report to the state	Includes average annual charges, charge estimates, actual charges			May legislate only most common procedures, only outpatient services, or all billable services	Price information is reported to the state		Price information is available to an individual upon request	Price information is available in a publicly available report		
Virginia	STATUTE(S): Virginia Code §32.1-276.5:1 ENACTED BILL(S): Added: H.B. 603 (2008) Amended: S.B. 396 (2008)	Added: 2008 Amended: 2008	"for all providers and provider types, to include hospitals, outpatient or ambulatory surgery centers and physician offices"	"carriers offering private group health insurance policies"			"the average reimbursement paid for a specific service" AND "the same services provided for reimbursement by fee-for-service Medicare and Medicaid"	"a minimum of 25 most frequently reported health care services which may include inpatient and outpatient diagnostic services, surgical services or the treatment of certain conditions or diseases"	"managed by the Commissioner"					

STATE LAWS ON HEALTH CARE PRICE TRANSPARENCY AND DISCLOSURE											
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Virginia	STATUTE(S): Virginia Code §32.1-276.4, 32.1-276.5:1, 32.1-276.6 ENACTED BILL(S): Added: H.B. 1307 (1996), H.B. 603 (2008); Amended: S.B. 396 (2008), H.B. 710 (2010), H.B. 343 (2012), S.B. 135 (2012)	Added: 1996, 2008 Amended: 2008, 2010, 2012	"for all providers and provider types, to include hospitals, outpatient or ambulatory surgery centers and physician offices"	"carriers offering private group health insurance policies"	"price information" AND "total charges"	"the aggregate information so that readers will be able to determine the average amount of reimbursement paid"		"The Commissioner shall negotiate and enter into contracts or agreements with a nonprofit organization for the compilation, storage, analysis, and evaluation of data submitted by health care providers pursuant to this chapter; for the operation of the All-Payer Claims Database"		"public survey reports"	"shall be made available to the public through an Internet Website operated by the contracting organization" AND "shall take steps to increase public awareness of the data and information available through the nonprofit organization's website and how consumers can use the data and information when making decisions about health care providers and services"

STATE LAWS ON HEALTH CARE PRICE TRANSPARENCY AND DISCLOSURE											
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Washington	STATUTE(S): Revised Code of Washington §70.41.250 ENACTED BILL(S): Added: S.S.S.B. 5304 (1993)	Added: 1993	"the hospital"		"charges"		"all health care services ordered"		"made available to any physician and/or other health care provider ordering care in hospital inpatient/outpatient services. The physician and/or other health care provider may inform the patient of these charges and may specifically review them"		Unlegislated Washington Hospital
West Virginia	STATUTE(S): West Virginia Codes §§16-29B-1, §16-29B-18, §16-29B-21, §16-29B-25 ENACTED BILL(S): Added: 1983; Amended: H.B. 2194 (1991), S.B. 458 (1997)	Added: 1983 Amended: 1991, 1997	"health care providers"		"health care costs"			"an entity of state government must be given authority [...] to gather and disseminate health care information"		"to analyze and report on changes in the health care delivery system" AND "publish and disseminate any information which would be useful to members of the general public in making informed choices about health care providers"	

STATE LAWS ON HEALTH CARE PRICE TRANSPARENCY AND DISCLOSURE											
			SCOPE OF HEALTH CARE PROVIDERS		SCOPE OF PRICE		SCOPE OF SERVICES		LEVEL OF TRANSPARENCY		
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West Virginia	STATUTE(S): West Virginia Codes §16-5F-2 ENACTED BILL(S): Added: 1979; Amended: H.B. 2194 (1991)	Added: 1979 Amended: 1991, 1996	"Every covered facility and related organization"		"A complete schedule of such covered facility's or related organization's then current rates" AND "A statement of all charges"			"file with the board"	"Copies of such reports shall be made available to the public upon request"		
Wisconsin	STATUTE(S): Wisconsin Statutes §153.05 (1)(a) ENACTED BILL(S): Added: AB 907 §11-31 (2005)	Added: 2005	"health care providers other than hospitals and ambulatory surgery centers"		"health care information"					"disseminate [...] in language that is understandable to laypersons.	
	STATUTE(S): Wisconsin Statutes §153.05 (1)(c) ENACTED BILL(S): Added: AB 907 §11-31 (2005)	Added: 2005		"insurers" and administrators"	"health care claims information with respect to the cost, quality, and effectiveness"			"the data organization under contract"			"shall analyze and publicly report [...] in language that is understandable by lay persons"
	STATUTE(S): Wisconsin Statutes §153.05 (2m)(a) & (8)(b) ENACTED BILL(S): Added: AB 907 §11-31 (2005)	Added: 2005	"hospitals and ambulatory surgery centers"		"claims information and other health care information"			"a [contracted] entity"			
	STATUTE(S): Wisconsin Statutes §153.05 (8)(a) ENACTED BILL(S): Added: AB 907 §11-31 (2005)	Added: 2005	"from health care providers, other than hospitals and ambulatory surgery centers"		"claims information and other health care information"			"the department shall collect"		"disseminate, in language that is understandable to laypersons"	

STATE LAWS ON HEALTH CARE PRICE TRANSPARENCY AND DISCLOSURE											
			SCOPE OF HEALTH CARE PROVIDERS		SCOPE OF PRICE		SCOPE OF SERVICES		LEVEL OF TRANSPARENCY		
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Wisconsin	STATUTE(S): Wisconsin Statutes §153.05 (8)(c) ENACTED BILL(S): Added: AB 907 §11-31 (2005)	Added: 2005		"insurers and administrators"	"health care claims information"			"the data organization"		publicly report, in language that is understandable to laypersons	
	STATUTE(S): Wisconsin Statutes §153.08 ENACTED BILL(S): Added: AB 907 §11-31 (2005)	Added: 2005	"hospital"		"rates or charge [change]"					"published a class 1 notice [...] in a newspaper"	
	STATUTE(S): Wisconsin Statutes §153.22 ENACTED BILL(S): Added: AB 907 §11-31 (2005)	Added: 2005	"hospitals and ambulatory surgery centers"		"utilization, charge, and quality data on patients"					"annual report"	
	STATUTE(S): Wisconsin Statutes §153.45 ENACTED BILL(S): Added: AB 907 §11-31 (2005)	Added: 2005	"health care provider that is not a hospital or ambulatory surgery center"		"Charges assessed with respect to the procedure code"					"public use data files"	
	STATUTE(S): Wisconsin Statutes §146.903 (3)(a) ENACTED BILL(S): Added: AB 907 §11-31 (2005)	Added: 2005	"health care provider or the health care provider's designee"		"the median billed charge, assuming no medical complications"		"for a health care service, diagnostic test, or procedure"		"upon request by and at no cost to a health care consumer"		

STATE LAWS ON HEALTH CARE PRICE TRANSPARENCY AND DISCLOSURE											
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STATE	LAWS	YEAR	Scope of Health Care Providers	Insurers are required to report? (Not factored in grading)	Charge	Paid Amount	Scope of Services	Reported to the State	Available upon request (1)	Available in Report	Available on Website
Description	Relevant statute(s) with a hyperlink to the text and all relevant enacted bills with available hyperlinks	If available, date of enactment	May legislate hospitals, surgical centers, or all providers including individual physicians	May legislate health plans, insurers, or carriers to report to the state	Includes average annual charges, charge estimates, actual charges	Demonstrates accepted reimbursement rates from different payers	May legislate only most common procedures, only outpatient services, or all billable services	Price information is reported to the state	Price information is available to an individual upon request	Price information is available in a publicly available report	Price information is available on a website
Wisconsin	STATUTE(S): Wisconsin Statutes §146.903 (3)(b) ENACTED BILL(S): Added: AB 614 §5 (2009)	Added: 2009	"a health care provider" EXCEPT "A health care provider that is an association of 3 or fewer individual health care providers"		"charge information" AND "1. The median billed charge; 2. If the health care provider is certified as a provider of Medicare, the Medicare payment to the provider; 3. The average allowable payment from private, 3rd-party payers"		"25 presenting conditions identified"		"upon request by and at no cost to a health care consumer, provide the consumer a copy of the document"		"may make the information available by attaching it to the document or by including the address of an Internet site where the information is posted" Wisconsin Price Point
	STATUTE(S): Wisconsin Statutes §146.903 (4)(a) ENACTED BILL(S): Added: AB 614 §5 (2009)	Added: 2009	"Each hospital"		"charge information" AND "1. The median billed charge; 2. The average allowable payment under Medicare; 3. The average allowable payment from private, 3rd-party payers"		"for inpatient care for each of the 75 diagnosis-related groups [...] and for each of the 75 outpatient surgical procedures identified"		"A hospital shall, upon request by and at no cost to a health care consumer, provide the consumer a copy of the document"		"may make the information available by attaching it to the document or by including the address of an Internet site where the information is posted" Wisconsin Price Point
Wyoming	UNLEGISLATED: Developed by Wyoming Hospital Association with data from Hospital Industry Data Institute.		"all Wyoming hospitals"		"charge information"						Wyoming Price Point

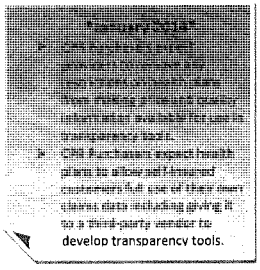
CATALYST FOR PAYMENT REFORM

STATEMENT BY CPR PURCHASERS ON PRICE AND QUALITY TRANSPARENCY IN HEALTH CARE

Information about the price and quality of health care services should be broadly available to those who use and pay for care

1. **Consumers must have access to meaningful, comprehensive information about the price and quality of services to make informed health care decisions.**
   - Consumers are being asked to pay more for their health care as costs rise and insurance benefits change; they have the right to know the price and quality of their health care choices.
   - Such information should be readily available and accessible in a comprehensive format that is relevant and user-friendly, including:
     - ✓ Integrated price, quality (especially outcomes data), and patient experience information for specific services that is customized to the consumer's benefit design (e.g., real-time deducible, coinsurance, and co-pay information, etc.), by illustrating the total cost of care and the amount for which the consumer is responsible.
     - ✓ Provider background, including education and medical training, Maintenance of Certification, services offered, access hours, location and online appointment scheduling; and
     - ✓ An easy-to-use and convenient platform or portal including web and mobile applications, paired with support from physicians, nurses, coaches or other trained customer service representatives to help patients use the tools to maximize their health.

2. **Providers and health plans must make such information available.**
   - Health plans have made strides and should continue to innovate with the tools they have created to share quality and price information with consumers.
   - Some providers continue to resist releasing price and quality information. To develop comprehensive transparency tools, providers must make such data available, and provide it at a level which is meaningful to consumers (e.g. at the individual hospital or physician level rather than at a health system level).
   - Many health plans have agreed that self-insured purchasers should be able to use their own claims data, including price information, as needed, though some prohibit purchasers from giving it to a third-party vendor to develop consumer transparency tools or to assist with interpretation. Health plans must eliminate these restrictions to maximize the options for transparency tools in the marketplace.



3. **Self-insured purchasers have the right to use their claims data to develop benefit designs and tools that meet their needs.**
   - Self-insured purchasers have an interest in sharing price and quality information with their consumers to encourage them to use high-quality, cost-effective care, which may help to drive down health care spending and health care prices by encouraging providers to compete on quality and affordability.
   - Access to the most complete price and quality information also helps purchasers develop innovative and integrated benefit design and payment reform strategies.
   - Self-insured purchasers should seek health plan partners with tools that meet their needs or that allow them to use their own claims data in a manner that meets their needs, such as having the flexibility to contract with other vendors to analyze and display their data.

4. **Current anti-trust laws should be adhered to and enforced to ensure that providers and health plans do not use price information in an anti-competitive manner.**
   - There could be unintended negative consequences to greater transparency on price and quality information, such as providers using it to raise their prices. To address this, appropriate parties must monitor such transparency with suitable oversight mechanisms.
   - Price and quality information released for use by consumers can be presented in such a way that targets it to consumers' expected share of the costs due to their specific health plan benefit design.

Statement of Paul B. Ginsburg, Ph.D.
President, Center for Studying Health System Change (HSC)
Research Director, National Institute for Health Care Reform (NIHCR)

BEFORE THE U.S. SENATE
Committee on Finance

Hearing on "High Prices, Low Transparency: The Bitter Pill of Health Care Costs"

June 18, 2013

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THE NONPARTISAN CENTER FOR STUDYING HEALTH SYSTEM CHANGE (HSC) IS AFFILIATED WITH MATHEMATICA POLICY RESEARCH

Chairman Baucus, Senator Hatch and members of the Committee, thank you for the invitation to testify on health care price transparency and costs. My name is Paul Ginsburg, president of the Center for Studying Health System Change (HSC) and research director of National Institute for Health Care Reform (NIHCR).

Founded in 1995, HSC is an independent, nonpartisan health policy research organization affiliated with Mathematica Policy Research. HSC also has served since 2008 as the research arm of the nonpartisan, nonprofit National Institute for Health Care Reform (www.nihcr.org), a 501(c) (3) organization established by the International Union, UAW; Chrysler Group LLC; Ford Motor Company; and General Motors to conduct health policy research and analysis to improve the organization, financing and delivery of health care in the United States.

Our goal at HSC is to inform policy makers with objective and timely research on developments in the health care system and their impact on people. We do not make specific policy recommendations. Our various research and communication activities may be found on our Web site at www.hschange.org.

Health Care Costs and Price Transparency

To date, most policy activity related to health care price transparency has missed the mark and has not achieved the prime goal of lowering prices by engaging consumers to choose providers on the basis of value. Without changes in insurance benefit designs that steer patients to high-value providers—those that provide high-quality care efficiently—price transparency initiatives are likely to continue to have limited impact. Additionally, the effectiveness of price transparency approaches is limited by a lack of useful quality information for consumers. I do believe, though, there is a role for federal and state policy to achieve lower prices through price transparency initiatives that engage consumers.

One source of confusion in discussions of price transparency comes from the fact that there are different goals for price information, and distinct audiences with different needs. The importance of transparency as a core value of our society continues to grow, and, by this light, transparency is a goal in and of itself. We have a shared belief that the public or individual consumers should know more about the products and services they are buying and what they cost, even in situations where someone else is paying. Some of the interest in price transparency on the part of policy makers reflects this important shared value. But the chief goal of price transparency initiatives is to encourage competition among providers on the basis of both price and quality of care. To the extent that consumers choose higher-value providers, they will save money and get higher-quality care. And, if enough consumers act on the basis of price and quality information, providers will feel significant market pressure to reduce prices and increase the quality of care. Such a market level effect will benefit all who use and pay for care.

At least three distinct audiences have the potential to benefit from health care price information. One audience is individual patients deciding what care to get and which provider to use. Patients need to know the differences in what they will pay if they choose different providers. The second audience consists of employers that purchase health benefits for their employees. For this audience, learning that prices vary a great deal from one provider to another, often in a way

unexplained by quality differences, can be very influential. Employers can change insurance benefit and network designs to make employees more sensitive to price and shift use of services to higher-value providers. The third audience is policy makers, who can pursue approaches to increase the degree of price competition in the market or, in some cases, regulate prices directly.

Transparency Initiatives are Coming Closer to the Mark

The earliest policy initiatives to promote price transparency required hospitals to publish their "chargemasters," which are list prices for thousands of services that hospitals provide, down to provision of an aspirin. Publishing chargemasters does not have the potential to lead to lower prices by engaging consumers, because the price information is far too complex to be useful, and does not reflect the prices most consumers and health plans actually pay. A later generation of initiatives reported average hospital prices for common treatments, such as a knee replacement. These data are more understandable to consumers and policy makers, but the price data are typically for list prices (billed charges). These are not very meaningful to policy makers or to consumers, however, because private insurers negotiate large discounts and public programs (Medicare and Medicaid) set payment rates administratively.

The Centers for Medicare and Medicaid Services (CMS) recently released hospital charges for common episodes of care along with Medicare payment amounts for those services.[1] For one audience—individual patients, these charges are generally irrelevant. They do not reflect what anyone pays for care, except for the few uninsured patients who can afford a hospitalization and a small number of privately-insured patients who choose a hospital not in their insurer's provider network. The Medicare inpatient payment amounts are irrelevant to Medicare patients, who pay the same deductible regardless of which hospital they use. And, what Medicare pays clearly isn't relevant to privately-insured patients. To me, the most important information from the CMS charge data was generated by a *New York Times* article about the hospital with the highest charges in the country, Bayonne Hospital in New Jersey. This information was important because it shed light on a relatively new business strategy where some hospitals refuse to contract with insurers and instead set extremely high charges, aiming to collect these amounts from insurers whose enrollees visit the hospital's emergency department.

The Massachusetts Attorney General (AG) in 2010 published much more meaningful price data, which have been influential with Massachusetts policy makers and employers and perhaps outside the state as well.[2] The AG report published data on the actual rates that private insurers paid for hospital care. It showed very large differences in rates across hospitals, with some of the highest-priced hospitals turning out to be the highly prestigious ones, but others apparently high priced because of a lack of local competitors. The report was an important factor behind 2010 Massachusetts legislation that prohibited hospitals from requiring placement in preferred tiers as a condition of contracting. This has opened the door to much greater enrollment in

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[1] Administration Offers Consumers an Unprecedented Look at Hospital Charges, May 8, 2013. http://www.cms.gov/Newsroom/MediaReleaseDatabase/Press-Releases/2013-Press-Releases-Items/2013-05-08.html

[2] Office of Attorney General Martha Coakley, Examination of Health Care Cost Trends and Cost Drivers pursuant to g.l. c. 118g, § 6 ½(b): Report for annual public hearing (Mar. 16, 2010), *available at* http://www.mass.gov/Cago/docs/healthcare/final_report_w_cover_appendices_glossary.pdf

insurance products that differentiate hospital deductibles according to the tier of the hospital used.

I and others have raised the concern that the publication of negotiated rates could raise prices. There is evidence, albeit from outside the health care industry, that in concentrated markets price disclosure leads to higher prices.[3] Indeed, antitrust authorities throughout the world generally restrict how sellers publicly post prices.[4] Anecdotal information from some health care price transparency initiatives suggests that low-priced providers were unaware of their prices being substantially lower than those of their competitors. At this point, we can only guess about whether some providers subsequently succeeded in raising prices; I expect research to be appearing on this issue in the future.

Role of Insurance Benefit Design

For price information to influence consumers to choose different providers, those choosing lower-priced providers need to save money as a result. Enrollment in high-deductible plans has been growing rapidly, which makes individuals more aware of the prices they are paying for health services. But, even high-deductible plans likely have little influence inpatient hospital choice because the cost of almost all inpatient admissions will exceed the deductible. And, many current insurance benefit designs lead to patients paying the same amount regardless of provider. For example, many plans have uniform hospital deductibles physician copayments. The most important aspect of current benefit designs is the incentive to use network providers. Since the late-1990s, most plans' hospital networks have been very broad; recently plans have introduced more products that achieve lower premiums by offering a limited provider network.

Newer benefit designs are more effective in helping consumers identify lower-priced providers and rewarding consumers who use such providers. For example, high-deductible plans do provide opportunities for enrollees to save money if they choose lower-priced providers of outpatient imaging and procedures. Tools to help enrollees find lower-priced providers have advanced. For example, I was impressed with the United Healthcare's *myHealthcare Cost Estimator* tool, which was sent to me (they administer my health plan) a few weeks ago.

However, I perceive the greatest potential to obtain lower prices comes from approaches where purchasers and health plans, rather than report prices to their enrollees, analyze extensive data on costs and quality and provide their enrollees very simple incentives to choose providers determined to be higher value. For example, for inpatient care, sophisticated insurers can analyze total spending for an episode of care, including all of the providers involved, including various physicians and post-acute care providers as well as the hospital, and factor in data on quality as well. Such number crunching is behind tiered-network products.

Reference pricing is a more focused version of the tiered-network approach. CalPERS, which purchases health benefits on behalf of California state employees and employees of many local

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[3] Ginsburg, Paul B. "Shopping for Price in Medical Care." *Health Affairs,* vol. 26, no. 2, March 2007, pp. w208-w216.

[4] A U.S. example is restrictions on airlines publicizing their prices.

governments, has used this approach for those enrolled in its preferred provider organization (PPO) plan administered by Anthem Blue Cross. For hip and knee replacements, CalPERS established a reference price on the basis of the average payment amount for the hospital bill (the surgeon's fee is not included in the program). Patients using hospitals where CalPERS pays more than that amount must pay the difference.

These approaches have the advantages of keeping things relatively simple for the enrollee, while being based on a sophisticated analysis of cost data. They do not fit with the common vision of transparency, such as when a plan provides prices on MRIs for those enrolled in a high-deductible design, but they may be more effective. Of course, the approaches can be combined, with network approaches used for inpatient care and price lists used for outpatient services. An irony is that hospital resistance has limited the development of tiered designs and reference prices, so that more growth has come in limited network plans, which are much more restrictive of provider choice.

Limited information on provider quality has held back the use of price transparency to obtain lower-priced care. Consumers need quality data that is meaningful to them before they decide to choose a lower-cost provider. Currently, perceptions of quality are based largely on reputation among clinicians, but it is by no means clear that a good reputation equates with better outcomes. Policy initiatives, such as Medicare Hospital Compare and the National Quality Forum, are helping to advance quality measurement and reporting, but much more could be done, especially shifting the focus from process measures to outcome measures of quality.[5]

Policies to Obtain Lower Prices through Transparency

Although I have been critical of many public price transparency efforts, federal and state policies can be effective. Two federal policies that are not transparency initiatives *per se* are likely to do a lot to change insurance benefit designs toward those that include incentives to choose lower-priced providers. I am referring to the "Cadillac tax" provision in the Affordable Care Act and the design of the premium credits to purchase coverage on insurance exchanges. The Cadillac tax will lead to strong incentives to keep premiums low enough to avoid the 40 percent excise tax. Since premium credits are based on the premium of the second least expensive silver plan in an area and do not vary according to the premium of the plan chosen by an enrollee, consumers will be highly sensitive to premiums charged. The Cadillac tax and premium competition in the exchanges will pressure plans to keep premiums down, and some of the tools that health plans will use will be higher deductibles, limited-provider networks, tiered networks and reference pricing. These benefit designs will increase consumer sensitivity to provider prices and consumer interest in tools to help them identify higher-value providers.

The federal government can support these approaches by making Medicare Part B claims data on physicians available to insurers and consumer organizations, which have been pressing for it for some time. This would allow insurers to assess physician efficiency and quality on the basis of

[5] See, for example, Berenson, Robert, "Seven Policy Recommendations to Improve Quality Measurement," Health Affairs Blog, May 22, 2013. http://healthaffairs.org/blog/2013/05/22/seven-policy-recommendations-to-improve-quality-measurement/

broader experience than they can obtain from their own claims data. Such a change would be particularly helpful to smaller insurers, thus making insurance markets more competitive. Legislation recently reintroduced by Senators Grassley and Wyden (Medicare DATA Act) would accomplish this. States can also contribute by designing their all-payer claims databases in a way that allows insurers to draw on the full database to assess the quality and efficiency of different providers. States can also facilitate use of tools such as tiered networks and reference pricing by prohibiting hospitals from blocking these tools through refusal to contract.

STATEMENT OF HON. ORRIN G. HATCH, RANKING MEMBER
U.S. SENATE COMMITTEE ON FINANCE HEARING OF JUNE 18, 2013
HIGH PRICES, LOW TRANSPARENCY: THE BITTER PILL OF HEALTH CARE COSTS

WASHINGTON – U.S. Senator Orrin Hatch (R-Utah), Ranking Member of the Senate Finance Committee, delivered the following opening statement at a committee hearing examining ways to improve transparency and lower healthcare costs in America:

Thank you, Mr. Chairman, for convening this hearing this morning. To be honest, I'm not sure where to begin.

As we all know, the original impetus for this hearing was the recent article in Time magazine about the costs associated with health care.

While that article didn't present much in the way of new information, it reminded all of us how complicated our healthcare system is and how our system of fee-for-service reimbursement has resulted in tremendous cost growth over the last two decades.

Congress has had discussions about the cost of healthcare for years. Unfortunately, I think the President's health care law missed a real opportunity to address these issues.

We know that there are many factors that drive up the cost of care, some appropriate, and some not.

Those of us who got through the more than 35 poges of the Time article know that each sector of the healthcare industry must play a part if we're going to be successful in creating o more rational ond affordable system.

Some have suggested comparing purchasing decisions in our healthcare system to those of other industries such as airlines, cars, or hotels. With those types of purchases, websites and other avenues exist that allow consumers to readily find price information and consumer reviews.

While I agree that this is a very rationol way to shop, we have to ocknowledge that healthcare is very different. Many factors go into pricing health care – factors such as specialty of provider, severity of patient condition, and level of resource use. And, different payers reimburse at different levels.

As many have noted, we have one of the best health care systems in the world. But there is a significant debote as to whether our outcomes are good enough to justify the costs.

This year, Americans will spend $2.8 trillion on healthcare and, of that, Medicare will spend $800 billion.

In Congress, we tend to focus mostly on spending in Medicare and other federal programs, but the enormous amount spent in the overall healthcare system needs to be examined.

For employers who provide coverage to their employees, the rising costs of goods and services that make up our healthcare system are very real. Increased costs mean less money that can be spent on wages or other benefits and, perhaps more importantly, less money to spend on hiring additional employees.

And, for individuals, as costs continue to increase and employers have to scale back, their out-of-pocket health care costs will only go up.

The issue that most directly affects people – whether they have health insurance or not – is their out-of-pocket costs. Most people aren't interested in irrelevant hospital charge-masters, or the details of health plan negotiations. They simply want to know what they'll be paying themselves at the end of the day.

For savvy consumers who will spend time up front researching cost and quality data, they want easy to understand information to help them make decisions. For others, it's as simple as receiving a bill that is, as they say, patient-friendly.

As I stated, this is a very complicated issue and many factors need to be considered.

Most of us would agree that competition in healthcare is generally a good thing. Hospitals, physicians, suppliers, and payers should all compete on quality and price, and consumers should benefit from this.

However, in many parts of the country, consolidation – whether it is provider or payer consolidation – has often led to higher prices, without better quality outcomes.

Mr. Chairman, I think this is an area that is worth further exploration in the future.

Many of the policies that Congress has enacted – like, for example, accountable care organizations, bundled payments, or health information technology requirements – lead to greater consolidation. It's important that we know the consequences of some of these policies.

Lastly, let me echo the point made in Mr. Brill's article about the cost of defensive medicine.

As the article stated, much of the high cost of health care is due to over-utilization of services as a means of protecting the physician against future litigation.

In light of this fact, I hope that Congress will work to pass legislation to address medical liability reform. This was another missed opportunity in Obamacare, but it's not too late to fix that.

Chairman Baucus, thank you, once again, for convening this hearing today and I look forward to hearing from our witnesses and learning about how we can harness the wealth of information available to consumers to help them make good decisions about their health care.

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COMMUNICATIONS

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Statement

of the

American Hospital Association

before the

Committee on Finance

of the

United States Senate

Health Care Price Transparency

June 18, 2013

On behalf of our nearly 5,000 member hospitals, health systems and other health care organizations, and our 43,000 individual members, the American Hospital Association (AHA) appreciates this opportunity to submit for the record comments on the current state of health care costs and price transparency.

A BROKEN SYSTEM

Hospitals work within a fragmented health care system and complex billing structure that all parties – hospital leaders, regulators, insurers and patients – agree needs to be updated. But hospitals' mission remains the same: to serve the health care needs of the people in their communities 24 hours a day, seven days a week.

Nationally, hospitals deal with more than 1,300 insurers, each having different plans, all with multiple and often unique requirements for hospital bills. Add to that decades of governmental regulations that have made a complex billing system even more complex and frustrating for everyone involved. In fact, Medicare rules and regulations alone top more than 130,000 pages, much of which is devoted to submitting bills for payment. Clearly, this is an unworkable system.

It is important to note that what is charged and what patients eventually pay are two different numbers. Because nearly all of a hospital's payments are set either by government, which pays less than the cost of caring for patients, or through negotiations with private insurance companies, the vast majority of patients do not pay what is listed on the hospital bill.

In addition, hospitals must balance needed financial assistance for some patients with broader fiscal responsibilities in order to keep their doors open for all who need care.

Patients may look at a hospital bill and think the prices they see only reflect the direct care they received, when in fact what is reflected are all the resources required to provide the care – such as the nurse at the bedside and the myriad staff who keep the hospital running– bundled into the price of every item on a hospital bill.

Making life-saving services such as neonatal intensive care units, trauma centers and burn units available 24 hours a day, seven days a week, is cost intensive. This standby capacity is not explicitly funded, but patients and communities depend on it – and expect it – to be there when they need it because hospitals treat everyone who walks through their emergency department doors, including people who do not have insurance or cannot pay. In 2011 alone, hospitals provided $41 billion in uncompensated care. The cost of covering these patients, along with making up for payment shortfalls by government programs, are built into all bills as well.

THE CHALLENGE OF PROVIDING MEANINGFUL INFORMATION

Hospitals strive to provide care to those who need it while ensuring that patients have the necessary information – including the cost and quality of care – to make decisions about their care. Sharing meaningful information, however, is challenging because hospital care is specifically tailored to the needs of each individual patient. For example, a gallbladder operation for one patient may be relatively simple, but for another patient, it could be fraught with unforeseen complications, making meaningful "up front" pricing difficult and, perhaps, confusing for patients. Moreover, hospital prices do not include physician and other professionals' costs or, most importantly, how much of the cost a patient's insurance company may cover.

More than 40 states already require or encourage hospitals to report information on hospital charges or payment rates and make that data available to the public. These state efforts range from making public information about individual hospitals' lists of prices (i.e., master charges), to pricing information on frequent hospital services, to information on all inpatient services.

The AHA supports these state-based efforts regarding price transparency, including the *Health Care Price Transparency Promotion Act of 2013* (H.R. 1326), which would require states to have or establish laws requiring hospitals to disclose information on charges for certain inpatient and outpatient services, and require health insurers to provide to enrollees upon request a statement of estimated out-of-pocket costs for particular health care items and services. Introduced in the House by Reps. Michael Burgess (R-TX) and Gene Green (D-TX), the legislation also requires the Agency for Healthcare Research and Quality to study the types of health care cost information that consumers find useful, and ways it might best be distributed.

Hospitals are committed to providing more useful information to patients. It also is important to note that, for most patients, what is most important and relevant is how much they will be required to pay out-of-pocket. Because insurers determine how high their customers' out-of-pocket rates will be, patients need insurers to provide real-time information.

PRINCIPLES FOR HELPING PATIENTS WITH PAYMENT FOR HOSPITAL CARE

Today's complex billing system did not develop overnight, so it will require thoughtful examination involving all stakeholders to find the right solutions that will benefit patients.

In November 2003, the AHA Board of Trustees approved a Statement of Principles and Guidelines on practices hospitals are embracing for patient billing and collection. The guidance was updated in May 2012 to reflect advancements in the field and changes made by the *Patient Protection and Affordable Care Act* (ACA) applicable to tax-exempt hospitals. The guidelines reflect that commitment and demonstrate the shared partnership/responsibility between hospitals and patients to address billing issues in a timely, transparent and forthright manner. Moreover, the AHA Board of Trustees is developing a plan to continue to improve the billing system.

America's hospitals are united in providing care based on the following:

- **Communicating effectively with patients** – Hospitals work to provide financial counseling to patients about their bills and make the availability of such counseling widely known. Hospitals strive to respond promptly to patients' questions about their bills and to requests for financial assistance, and use a billing process that is clear, concise, correct and patient friendly. Hospitals are making available for review by the public specific information in a meaningful format about what they charge for items and services.

- **Helping patients qualify for financial assistance** – For years, hospitals have worked with patients to help them with their bill as part of their mission of caring. Under the ACA, non-profit hospitals have a written financial assistance policy that includes eligibility criteria, the basis for calculating charges and the method for applying financial assistance. Hospitals work to communicate this information to patients in a way that is easy to understand, culturally appropriate, and in the most prevalent languages used in their communities, and have understandable, written policies to help patients determine if they qualify for public assistance programs or hospital-based assistance programs. The ACA also requires that non-profit hospitals widely publicize (e.g., post on the premises and on the website and/or distribute directly to patients) these policies and share them with appropriate community health and human services agencies and other organizations that assist people in need.

- **Ensuring hospital policies are applied accurately and consistently** – Hospitals work to ensure that all financial assistance policies are applied consistently and that staff members who work closely with patients (including those working in patient registration and admitting, financial assistance, customer service, billing and collections as well as nurses, social workers, hospital receptionists and others) are educated about hospital billing, financial assistance and collection policies and practices.

- **Making care more affordable for patients who qualify for financial assistance –** Hospitals strive to review all current charges and ensure that charges for services and procedures are reasonably related to both the cost of the service and to meeting all of the community's health care needs, including providing the necessary subsidies to maintain essential public services. Under the ACA, non-profit hospitals also have policies to limit charges for emergency and other medically necessary care for those who qualify for financial assistance to no more than the amounts generally billed to individuals who have insurance covering such care.

CONCLUSION

Hospitals are a critical component to the fabric and future of our communities. We recognize the costs associated with health care and have worked hard to hold down our costs. Some progress has been made, with recent data clearly showing that hospital costs and price growth have slowed; the rate of growth in hospital cost per service, at only 2.1 percent, is below inflation and at a decade-low. Hospitals remain committed to helping bend the cost curve for their patients, communities and the nation.

We agree that consumers need useful information when making health care-related decisions for themselves and their families. Providing understandable and useful information about health care costs is just one way America's hospitals are working to improve the health of their communities.

The AHA and its members stand ready to work with policymakers on innovative ways to build on efforts already occurring at the state level, and share information that helps consumers make better choices about their health care.

THE FEDERATION OF AMERICAN HOSPITALS

PRESENTS A

STATEMENT FOR THE RECORD

BEFORE

THE SENATE COMMITTEE ON FINANCE

HIGH PRICES, LOW TRANSPARENCY:
THE BITTER PILL OF HEALTH CARE COSTS

JUNE 18, 2013

On behalf of our member hospitals, the Federation of American Hospitals ("FAH") appreciates the opportunity to provide our views to the Senate Finance Committee concerning today's hearing on *High Prices, Low Transparency: The Bitter Pill of Health Care Costs*. The FAH is the national representative of more than 1,000 investor-owned or managed community hospitals and health systems throughout the United States. Our members include teaching and non-teaching hospitals in urban and rural parts of the United States, as well as inpatient rehabilitation, psychiatric, long-term acute care, and cancer hospitals.

We commend the Committee on its leadership in addressing the need for greater, and more accurate, transparency across our health care system. We agree with those that consider it critical for consumers to have relevant, up-to-date and useful information so they can meaningfully compare health plans, choose health insurance coverage that best meets a patient's medical needs, and make treatment choices that best meet their individual needs. This should be based on what is important to consumers, which is what they will pay for coverage and their out-of-pocket costs.

HEALTH INSURANCE TRANSPARENCY: WHAT PATIENTS NEED TO KNOW

Hospitals' mission is to care for patients regardless of when a medical need or crisis strikes. This is why our local hospitals provide compassionate round-the-clock care, including comprehensive emergency care to patients every day of the year, regardless of ability to pay. Patients who are uninsured or underinsured are typically eligible for charity care or generous discount policies to help ensure that the amount they may owe for the cost of that care is affordable.

Most hospital patients are insured, and with the implementation of the *Patient Protection and Affordable Care Act* ("ACA"), tens of millions more will have this protection. The ACA also promotes transparency of meaningful information that will strengthen everyone's ability to become more active and prudent purchasers of health care, enabling them to shop for and compare health insurance plans and choose the plan that best meets their medical needs.

Specifically, the ACA contains extensive, broad-based health insurance transparency provisions aimed at providing millions of consumers – whether they are currently insured or will purchase insurance for the first time through an Exchange – with the tools they need to understand easily the reality of how each health plan will work and what it will cost. This transparency necessarily is required before a patient chooses a health plan so that patients will no longer have to be surprised after they access treatment thinking they have health insurance, only to be denied coverage, after the fact, for some unknown or attenuated reason.

The ACA requires health plans (offering group and individual coverage) to provide enrollees and applicants with a uniform summary of benefits and coverage (SBC) so that consumers can compare health care coverage, including cost-sharing, limits, exceptions, reductions and coverage. The SBC must be written in plain language and contain no fine print, and must include examples to illustrate common benefits scenarios, including pregnancy and serious or chronic medical conditions and related cost-sharing. The ACA provides the Secretary with broad authority to implement these provisions and require plans to provide consumers with the information they need to compare health plans.

Further, the law requires all health plans to provide certain information to help consumers understand how reliably the plan reimburses claims for covered services, a plan's network adequacy, and other practical information, such as the number of claims denied, payment policies and practices, rating practices, cost-sharing and payment for out-of-network coverage, enrollee rights, and other important information. The ACA also provides that Exchanges, upon request of an individual, must require qualified health plans to give consumers cost-sharing information for specific items and services in a timely manner through at least an Internet website and otherwise for those without access to the Internet.

These provisions are sound public policies that are steps in the right direction, and the FAH strongly supports them. The Department of Health and Human Services ("HHS") has taken steps to implement some of these policies and should continue to do so to ensure the maximum benefits of transparency for consumers. The Committee should consider exercising

oversight over HHS to ensure the Department is implementing these provisions to the fullest extent. When shopping for health care coverage, not only are quality metrics important, but a smart consumer will want to know what a health insurance plan will cost them and their families out-of-pocket. They will want that information to perhaps compare among and between insurers so they can make wise decisions prior to enrollment. Further, once enrolled in an insurance plan, the enrollee should have up-to-the minute access to out-of-pocket cost-sharing information to help make their medical treatment choices. This is the information that will drive marketplace competition and greater efficiency in health care delivery.

Ideally, this transparency should extend across an entire episode of care. Patients often are furnished care by separate providers during a single episode of care, and these providers may bill the patient separately. The health plan is in the best position to provide all of the information to the consumer in "one-stop" shopping. Thus, logic dictates that the health plans should be required to provide estimates of the cost of care based on specific services provided by specific providers involved in providing the care.

Therefore, the FAH urges the Committee to encourage HHS to expedite implementation of the ACA provisions requiring health plans to provide consumers with cost-sharing and other key information prior to choosing a plan and getting medical treatment. The Committee should also ensure health plans comply with these important ACA provisions. Further, the Committee should ensure that the Administration's proposal to encourage "health care data pricing centers" results in states and insurance companies working together to provide useful cost sharing information that would allow Americans to be better informed. All of these initiatives are critical for consumers to make meaningful decisions about their health care.

HOSPITAL COST TRANSPARENCY: CMS MISSES THE MARK BY PROVIDING INCOMPLETE INFORMATION FOR CONSUMERS

The ACA also contains a provision requiring hospitals annually to make public, in accordance with guidelines developed by the Secretary, a list of standard charges for hospital services, including DRGs. Instead of working with hospitals to issue guidelines to implement this provision, the Centers for Medicare and Medicaid Services ("CMS") recently released hospital charge data for Medicare inpatient and outpatient procedures. The FAH supports efforts to promote transparency and provide quality and price information that enhances consumer choice. Yet, CMS's hospital charge data misses the mark in providing true price transparency to consumers. Indeed, it would have been more meaningful for consumers as well as policymakers to list Medicare payments compared to costs. That data would have revealed how far Medicare payments fall below the cost of care for seniors and disabled Americans – six percent through 2013, as projected by the Medicare Payment Advisory Commission ("MedPAC").

Unfortunately, the CMS charge data release is more likely to confuse consumers than provide meaningful, useful information, and even worse, it could mislead consumers into making a wrong choice that could actually harm them. This is because the charges posted by CMS are not prices in the conventional sense that consumers think of them – that is, **the actual price patients are expected to pay for care**.

Neither the government nor insurers actually pay a hospital's full charge master rate. Most importantly, in most instances, it bears no relation to the out-of-pocket cost, or cost-sharing, that a health consumer will pay at their local hospital. Most United States citizens receiving treatment at hospitals are covered by private or public insurance (*e.g.*, Medicare or Medicaid), and the out-of-pocket costs for the overwhelming majority of Americans are determined by their insurer.

With regard to Medicare, the rates for both the service and cost sharing are set annually by CMS. Although Medicare requires hospitals, for cost reporting purposes, to submit full charges when submitting claims, the charges have virtually no direct relation to the payment that a hospital receives, which is fixed by law – payment that, as noted earlier, falls well below costs. Those payments are fixed for both the amount that the Medicare program pays and the Medicare beneficiary cost-share. The same scenario also exists for the Medicaid program – fixed payments, and payments below the cost of care.

Additionally, private insurers set their rates through negotiations with hospitals to establish a mutually agreed upon payment rate for services. From this rate, the insurers, not hospitals, decide how much of that rate a patient will pay out-of-pocket. That out-of-pocket figure is the real cost a patient sees in their insurance-provided explanation of benefits. Many families covered by private insurance are experiencing increases that employers and other payers are imposing on those with coverage, including higher out-of-pocket expenses for items and services such as prescription drug co-payments and doctor visits, as well as higher deductible payments, and higher premium sharing.

Even Americans not covered by Medicare, Medicaid or private insurance are not susceptible to a full charge master rate. As discussed above, hospitals have generous discount payment policies for uninsured or underinsured patients which limit how much they ultimately will be billed. Typically, that amount is no more than the amount an individual enrolled in a managed care plan or Medicare would pay.

Therefore, the CMS data release does not achieve the transparency goals of the ACA or provide consumers with the information they need to make their health care choices. In fact, it goes in the opposite direction. To focus on the charge master rates is a distraction.

We urge the Committee and Congress to take action to ensure the transparency provisions in the ACA are accomplished in a manner that helps consumers smartly and wisely shop for the health insurance plan that best suits their medical needs. We appreciate the opportunity to provide our views to the Committee, and look forward to our continued work with the Committee and Congress to ensure our patients receive the medical care they need in a cost-effective and meaningful cost-transparent manner.

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